CQUIN Indicator Specification Information on CQUIN 2017/18 - 2018/19

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This Annex was republished in **April 2018** under Gateway Reference **07725** with the following updates:

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1. The CQUIN scheme 2017/18 – 2018/19

This Annex sets out the technical specification for each of the indicators in the scheme.

This document should be read in conjunction with the 2017-2019 CQUIN guidance found at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

1. Improving staff health and wellbeing

There are three parts to this CQUIN indicator.

National CQUIN	Indicator	Indicator weighting (% of CQUIN scheme available)
CQUIN 1a	Improvement of health and wellbeing of NHS staff	33.3% of 0.25% (0.0834%)
CQUIN 1b	Healthy food for NHS staff, visitors and patients	33.3% of 0.25% (0.0833%)
CQUIN 1c	Improving the uptake of flu vaccinations for front line staff within Providers	33.3% of 0.25% (0.0833%)

Indicator 1a Improvement of health and wellbeing of NHS staff

Indicator 1a	
Indicator name	Indicator 1a: Improvement of staff health and wellbeing
Indicator weighting (% of CQUIN scheme available)	33.3% of 0.25% (0.0834%)
Description of indicator	Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress. The two questions do not have to be pre-selected before the staff survey results, with 50% of the value of this indicator relating to performance in one question and the remaining 50% of the value relating to performance in a second question. **Year 1** The 5 percentage point improvement should be achieved over a period of 2 years, with the baseline survey being the 2015 staff survey. **Year 2** The 5 percentage point improvement should be achieved over a period of 2 years, with the baseline survey being the 2016 staff survey. 1. **Question 9a**: Does your organisation take positive action on health and well-being? Providers will be expected to achieve an improvement of 5% points in the answer “yes, definitely” compared to baseline staff survey results or achieve 45% of staff surveyed answering “yes, definitely”. 2. **Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Providers will be expected to achieve an improvement of 5% points in the

Indicator 1a	
	answer “no” compared to baseline staff survey results or achieve 85% of staff surveyed answering “no”. 3. **Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? Providers will be expected to achieve an improvement of 5% points in the answer “no” compared to baseline staff survey results or achieve 75% of staff surveyed answering “no”.
Numerator	NHS staff survey results for the Provider **Year 1** **Question 9a:** 2017 number of responses of “yes, definitely” **Question 9b:** 2017 number of responses of “no” **Question 9c:** 2017 number of responses of “no” **Year 2** **Question 9a:** 2018 number of responses of “yes, definitely” **Question 9b:** 2018 number of responses of “no” **Question 9c:** 2018 number of responses of “no”
Denominator	NHS staff survey results for the Provider **Year 1** **Question 9a**: 2017 Total number of responses (*Yes, definitely/ Yes, to some extent/ No*) **Question 9b:** 2017 Total number of responses (*Yes/No*) **Question 9c:** 2017 Total number of responses (*Yes/No*) **Year 2** **Question 9a**: 2018 Total number of responses (*Yes, definitely/ Yes, to some extent/ No*) **Question 9b:** 2018 Total number of responses (*Yes/No*) **Question 9c:** 2018 Total number of responses (*Yes/No*)
Rationale for inclusion	Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. This figure excludes the cost of agency staff to fill in gaps, as well as the cost of treatment. As well as the economic benefits that could be achieved, evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients. The Five Year Forward View made a commitment ‘to ensure the NHS as an employer sets a national example in

Indicator 1a	
	the support it offers its own staff to stay healthy'. Linked to this commitment the Health & Wellbeing CQUIN introduced in 2016 encourages providers to improve their role as an employer in looking after employees' health and wellbeing. The 2018-19 CQUIN rewards organisations who make a sufficient impact on staff perceptions about the changes organisations make to improve health and wellbeing– via improvements to the health and wellbeing questions within the NHS staff survey. To help organisations meet the CQUIN target NHS England has developed a new 'Staff Health and Wellbeing Framework' which will be launched in Spring 2018. The Framework sets out the support that all NHS organisations should provide to their staff in order to promote health and wellbeing. The framework is based on evidence based best practice and has been jointly developed working with leading NHS organisations as well as NHS Employers, NHSI and PHE. The framework covers the following areas: • Enablers: cross-cutting activities that ensures staff health and wellbeing is effectively led, managed and embedded within wider organisational activities; • Mental health: guidance on how to identify, prevent and support staff to manage mental health issues; • MSK: guidance on how to identify, prevent and support staff to manage MSK issues; • Healthy lifestyles: guidance on how to promote healthy lifestyles and how to support staff with lifestyle change interventions. Tools will be made available to assist organisations in effectively utilising the Framework. These will include: • Diagnostic tool- this allows organisations to measure their current staff health and wellbeing offer against best practice; • Action planner- this guides organisations to develop an achievable plan to implement the Framework and support them to work towards the CQUIN targets.
Data source	The NHS Annual Staff survey **Question 9a**: Does your organisation take positive action on health and well-being? *Yes, definitely/ Yes, to some extent/ No* response. **Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? *Yes/No* response. **Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? *Yes/No* response.

Indicator 1a	
	Data should be taken from the 'Health and Wellbeing CQUIN data' from the Latest Results pages of the NHS Staff Survey Results website (http://www.nhsstaffsurveys.com). This data is unweighted.
Frequency of data collection	Annual release of staff survey results
Organisation responsible for data collection	National NHS staff survey co-ordination centre
Frequency of reporting to commissioner	On the publication of 2017 (year 1) & 2018 (year 2) staff survey – expected to be released in March 2018 & 2019 respectively
Baseline period/date	**Year 1** - 2015 staff survey – released in 2016 **Year 2** – 2016 staff survey- released in 2017
Baseline value	Individual trust performance against each staff survey question
Final indicator period/date (on which payment is based)	**Year 1** - Quarter 4, 2017/18 **Year 2** - Quarter 4, 2018/19 (NHS Annual Staff Survey results released)
Final indicator value (payment threshold)	Achievement of the 5% point improvement in 2 of the 3 questions in the staff survey results or achievement of the absolute targets in 2 of the 3 questions
Final indicator reporting date	**Year 1** – Publication of 2017 staff survey – expected in March 2018 **Year 2** – Publication of 2018 staff survey – expected in March 2019
Are there rules for any agreed in-year milestones that result in payment?	N/A
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes

Rules for partial achievement of indicator 1a

The partial payment structure below will be applied to each question individually. For instance, a 5% point improvement in question 9a and a 3% improvement in 9b would result in 75% payment of this indicator calculated by:

1.) Question 9a – 50% indicator weighting x 100% payment for achieving 5% improvement = 50%

2.) Question 9b – 50% indicator weighting x 50% payment for achieving 3% improvement = 25%

Total = 50%+25% = 75%

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
Less than 3% point improvement	0% payment of weighting associated to staff survey results
3% point (or above) and less than 4% improvement	50% payment of weighting associated to staff survey results
4% point (or above) and less than 5% improvement	75% payment of weighting associated to staff survey results
5% point or greater improvement or achievement of absolute threshold	100% payment of weighting associated to staff survey results

Indicator 1b Healthy food for NHS staff, visitors and patients

Indicator 1b	
Indicator name	Indicator 1b: Healthy food for NHS staff, visitors and patients
Indicator weighting (% of CQUIN scheme available)	33.3% of 0.25% (0.0833%)
Description of indicator	Providers will be expected to build on the 2016/17 CQUIN by: Firstly, maintaining the four changes that were required in the 2016/17 CQUIN in both 2017/18 & 2018/19 1. The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS)[1]; The following are common definitions and examples of price promotions: a. Discounted price: providing the same quantity of a product for a reduced price (pence off deal); b. Multi-buy discounting: for example buy one get one free; c. Free item provided with a purchase (whereby the free item cannot be a product classified as HFSS); d. Price pack or bonus pack deal (for example 50% for free); and e. Meal deals (In 2016/17 this only applied to drinks sold in meal deals. In 2017/18 onwards no HFSS products will be able to be sold through meal deals). 2. The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS); The following are common definitions and examples of advertisements: a. Checkout counter dividers b. Floor graphics c. End of aisle signage d. Posters and banners

[1] More specific information on the gram per 100g / per portion classifications can be found on page 19 in "Guide to creating a front of pack (FoP) nutrition label for pre-packed products sold through retail outlets":
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300886/2902158_FoP_Nutrition_2014.pdf

Indicator 1b	
	3. The banning of sugary drinks and foods high in fat, sugar or salt (HFSS) from checkouts; The following are common definitions and examples of checkouts: a. Points of purchase including checkouts and self-checkouts b. Areas immediately behind the checkout and; 4. Ensuring that healthy options are available at any point including for those staff working night shifts. We will share best practice examples and will work nationally with food suppliers throughout the next year to help develop a set of solutions to tackle this issue. Secondly, introducing three new changes to food and drink provision: **Year One (2017/18)** 1. 70% of drinks lines stocked must have less than 5 grams of added sugar per 100ml. In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml). 2. 60% of confectionery and sweets do not exceed 250 kcal. 3. At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g. **Year Two (2018/19)** The same three areas will be retained but a further shift in percentages will be required. The CQUIN will also be aligned with the national SSB voluntary reduction scheme which started during 17/18.

Indicator 1b	
	1. Outlets will be eligible for the CQUIN where they have signed up to the national SSB reduction scheme,[2] and total litres of SSBs sold account for 10% or less of all litres of drinks sold in 2018/19.[3] 2. 80% of confectionery and sweets do not exceed 250 kcal. 3. At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g.[4]
Numerator	In 2017/18 data should be collected at the local level based on individual contract arrangements. In addition to gathering local level data to assess compliance, in 2018/19 providers will need to submit data via NHS Digital SDCS to demonstrate to what extent the outlets operating on their premises are compliant with each CQUIN criterion. The single end of year national NHS Digital SDCS data submission to NHS England will require the following numerators: 2018/19 numerators: Number of outlets[5] compliant with each of the CQUIN criterion listed below: a. No price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS) b. No advertisements of sugary drinks and foods high in fat, sugar or salt (HFSS) c. All sugary drinks and foods high in fat, sugar or salt (HFSS) banned from checkouts d. Healthy options are available at any point including for those staff working night shifts (this criteria is measured at the provider level rather than for each

[2] A decision will be made during Quarter 1 of 2018/19 to determine if NHS England's voluntary SSB reduction scheme to reduce the sale of sugar-sweetened beverages (SSBs) has proven effective in significantly reducing the volume of SSBs sold on NHS premises and will continue, or if the ban on SSBs specified in provisions 19.4, 19.5 and 19.6 of the NHS Standard Contract will be implemented. This decision will be communicated to CCGs, Trusts and lead contacts for SSB data collection during Q1 2018/19. If the ban on the sale of SSBs is disabled or suspended, then this SSB element of this CQUIN scheme will continue as specified. If the ban does become effective from 1 July 2018, then the payment for this part of CQUIN 1b should be redistributed equally across the other parts of CQUIN 1b.

[3] In circumstances where it is not possible for sales information to be collected in litres, some outlets (such as some trolley services for example) can monitor the percentage of lines stocked, at an equivalent level to the thresholds for litres sold. The NHSE healthy workforce team (england.healthyworkforce@nhs.net) can be contacted for making these alternative arrangements.

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419245/balanced-scorecard-annotated-march2015.pdf

Indicator 1b	
	outlet) e. Total litres of SSBs sold are 10% or less of all litres of drinks sold f. 80% of confectionery and sweets not exceeding 250 kcal g. 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and not exceed 5.0g saturated fat per 100g
Denominator	In 2017/18 data should be collected at the local level based on individual contract arrangements. In addition to the local level data, in 2018/19 providers will need to submit data via NHS Digital SDCS to demonstrate to what extent the outlets operating on their premises are compliant with each CQUIN criterion. The single end of year national NHS Digital SDCS data submission to NHS England will require the following denominator: 2018/19 denominator: Total number of outlets.[5]
Rationale for inclusion	Any provider who does not sell food or drink on their site will not be eligible for the CQUIN. In these cases the weighting for this part (1b) will be added equally to parts 1a and 1c. PHE's report "Sugar reduction – The evidence for action" published in October 2015 outlined the clear evidence behind focussing on improving the quality of food on offer across the country. Almost 25% of adults in England are obese, with significant numbers also being overweight. Treating obesity and its consequences alone currently costs the NHS £5.1bn every year. Sugar intakes of all population groups are above the recommendations, contributing between 12 to 15% of energy. Consumption of sugar and sugar sweetened drinks tending to be highest among the most disadvantaged who also experience a higher prevalence of tooth decay and obesity and its health consequences. It is important for the NHS to start leading the way on tackling some of these issues, starting with the food and drink that is provided & promoted in hospitals. NHS England will continue with their work at a national level with the major food suppliers on NHS premises to ensure that NHS providers are supported to take action across all food and drink outlets on their premises.

[5] Outlets include all food and drink outlets, vending contracts and trolley services. This includes all in-house services (including voluntary organisations) and arrangements with external suppliers.

Indicator 1b	
Data source	Provider data collection and audit of outlets against compliance criteria as set out above. In 2018/19 data on compliance of outlets against each criterion should be submitted through NHS Digital SDCS collection.
Frequency of data collection	End of Quarter 4
Organisation responsible for data collection	• Providers to collect data on compliance for each of their outlets. Outlets include all food and drink outlets, vending contracts and trolley services. This includes all in-house services (including voluntary organisations) and arrangements with external suppliers. Additional information and a data collection template is available at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/ to assist with this. • In 2018/19 there should be an annual submission to NHS Digital on the compliance of outlets against each criterion. This information will be made available to your local CCG and NHS England.
Frequency of reporting to commissioner	End of Quarter 4
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	**Year 1** - End of Q4 2017/18 **Year 2** - End of Q4 2018/19
Final indicator value (payment threshold)	2 year CQUIN scheme: **Year 1** payment based on performance during 2017/18 50% payment is available where 2016/17 changes are maintained and 50% of the payment is available where the three new changes to the food and drink provision are introduced. **Year 2** payment based on performance during 2018/19 Final indicator value: 100% of outlets on provider's premises to be compliant against each criterion as follows: a. No price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS) b. No advertisements of sugary drinks and foods high in fat, sugar or salt (HFSS) c. All sugary drinks and foods high in fat, sugar or salt (HFSS) banned from checkouts d. Healthy options are available at any point including for those staff working night shifts (this criteria is

Indicator 1b	
	measured at the provider level rather than for each outlet) e. Compliant with the SSB policy requirements (as described in scenarios above) f. 80% of confectionery and sweets not exceeding 250 kcal g. 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and not exceed 5.0g saturated fat per 100g Payment schedule and rules for partial achievement set out below.
Final indicator reporting date	As soon as possible after Q4 2017/18 and Q4 2018/19
Are there rules for any agreed in-year milestones that result in payment?	No
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes, in the partial achievements section set out below.

Rules for partial achievement of indicator 1b

Year 1 payment based on performance during 2017/18

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
2016/17 changes maintained	50% payment
Year 1 changes introduced	50% payment
2016/17 changes maintained and Year 1 changes introduced	100% payment

Year 2 payment based on performance during 2018/19

Payments will be allocated for each sub-criterion based on the percentage of compliant outlets (outlets include all food and drink outlets, vending contracts and trolley services. This includes all in-house services, including voluntary organisations, and arrangements with external suppliers). A template is available at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/ to help to determine payment amounts.

The maximum amount of funding available for each sub-criterion is set out below:

Final indicator value for the partial achievement threshold	Criteria	Maximum % of CQUIN scheme available for meeting final indicator value	
2016/17 changes maintained	No price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS) in any outlet.	12.5%	50%
	No advertisements of HFSS food and drink in any outlet.	12.5%	
	No HFSS food and drink at checkouts in any outlet.	12.5%	
	Healthy options are available at any point including for those staff working night shifts.	12.5%	
2018/19 changes introduced	Trust is signed up to national SSB reduction scheme and total litres of SSBs sold are 10% or less of all litres of drinks sold in 2018/19 in all outlets.	20%	50%
	80% of confectionery and sweets not exceed 250kcal in any outlet.	15%	
	At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and not exceed 5.0g saturated fat per 100g in all outlets.	15%	

Indicator 1c Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff

Indicator 1c	
Indicator name	Improving the uptake of flu vaccinations for frontline clinical staff within Providers.
Indicator weighting (% of CQUIN scheme available)	33.3% of 0.25% (0.0833%)
Description of indicator	Year 1 - Achieving an uptake of flu vaccinations by frontline clinical staff of 70% Year 2 - Achieving an uptake of flu vaccinations by frontline clinical staff of 75% Note: Providers may need to provide evidence that further criteria have been implemented as a result of ongoing discussions on vaccination of frontline healthcare workers. Further information will be provided in due course
Numerator	Number of front line healthcare workers who have received their flu vaccination by February 28th 2018. Please refer to the Seasonal Influenza Frontline Healthcare Workers Vaccine Uptake Survey 2016/17 Guidance for detailed information on definitions. If organisations believe a significant proportion of staff are receiving their flu vaccines from other providers, they can include this in their returns if they wish to create an auditable scheme to demonstrate it.
Denominator	Total number of front line healthcare workers. Please refer to the Seasonal Influenza Frontline Healthcare Workers Vaccine Uptake Survey 2016/17 Guidance for detailed information on definitions.
Rationale for inclusion	Frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during winter months when some of their patients will be infected. It has been estimated that up to one in four healthcare workers may become infected with influenza during a mild influenza season - a much higher incidence than expected in the general population. Influenza is also a highly transmissible infection. The patient population found in hospital is much more vulnerable to severe effects. Healthcare workers may transmit illness to patients even if they are mildly infected. The green book recommends that healthcare workers

Indicator 1c	
	directly involved in patient care are vaccinated annually. It is also encouraged by the General Medical Council and by the British Medical Association. Specifically the green book states “Employers need to be able to demonstrate that an effective employee immunisation programme is in place, and they have an obligation to arrange and pay for this service. It is recommended that immunisation programmes are managed by occupational health services with appropriately qualified specialists. This chapter deals primarily with the immunisation of healthcare and laboratory staff; other occupations are covered in the relevant chapters.”[6]
Data source	Providers to submit cumulative data monthly on the ImmForm website. Full documentation on how to input data can be found here: https://www.gov.uk/government/publications/seasonal-influenza-frontline-healthcare-workers-vaccine-uptake-survey-data-collection-guidance Note: Providers may need to provide evidence that further criteria have been implemented as a result of ongoing discussions on vaccination of frontline healthcare workers. Further information will be provided in due course
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	**Year 1** - March 2018 **Year 2** - March 2019
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	**Year 1** - March 2018 **Year 2** - March 2019
Final indicator value (payment threshold)	**Year 1** – A 70% uptake of flu vaccinations by frontline healthcare workers **Year 2** - A 75% uptake of the flu vaccinations by frontline healthcare workers

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147882/Green-Book-Chapter-12.pdf

Indicator 1c	
Final indicator reporting date	As soon as possible after Q4 2017/18
Are there rules for any agreed in-year milestones that result in payment?	N/A
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes - see partial payment section

Rules for partial achievement of indicator 1c – Year 1

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
50% or less	No payment
50% up to 60%	25% payment
60% up to 65%	50% payment
65% up to 70%	75% payment
70% or above	100% payment

Rules for partial achievement of indicator 1c – Year 2

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
<50%	No payment
50% up to 59.99%	25% payment
60% up to 64.99%	50% payment
65% up to 74.99% uptake	75% payment
75% or above	100% payment

Supporting Guidance and References

Practical guidance and support for Providers will be provided by the beginning of March to help support them with the introduction of the initiatives & to help them promote uptake. However, NHS Employers already offer campaign advice for Providers.

http://www.nhsemployers.org/campaigns/flu-fighter/nhs-flu-fighter

2. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)

There are four parts to this CQUIN indicator.

National CQUIN	Indicator	Indicator weighting (% of CQUIN scheme available)
CQUIN 2a	Timely identification of sepsis in emergency departments and acute inpatient settings.	25% of 0.25% (0.0625%)
CQUIN 2b	Timely treatment for sepsis in emergency departments and acute inpatient settings.	25% of 0.25% (0.0625%)
CQUIN 2c	Antibiotic review.	25% of 0.25% (0.0625%)
CQUIN 2d	Reduction in antibiotic consumption per 1,000 admissions and proportion of antibiotic usage (for both in-patients and out-patients) within the Access AWaRe category.	25% of 0.25% (0.0625%)

Indicator 2a Timely identification of sepsis in emergency departments and acute inpatient settings

Indicator 2a	
Indicator name	Timely identification of patients with sepsis in emergency departments and acute inpatient settings
Indicator weighting (% of CQUIN scheme available)	25% of 0.25% (0.0625%)
Description of indicator	The percentage of patients who met the criteria for sepsis screening and were screened for sepsis. The indicator applies to adult and child patients arriving in hospital as emergency admissions and to all patients on acute in-patient wards. This applies in 17/18 and 18/19. During 18/19, acute and emergency units should be transitioning to use the National Early Warning Score (NEWS 2) to support screening of patients. By Q4 of 2018/19, payment will only be made if over 90% of screened cases have utilised NEWS 2 (where it is appropriate to use NEWS 2). This change is for consistency with the sepsis

Indicator 2a	
	implementation guidance and best available evidence. The 'screening for sepsis' involves a senior clinical decision-maker using their judgement to decide if it's likely that the patient has sepsis, and if so to start sepsis treatment. As NEWS 2 does not apply to paediatric patients or pregnant women, we expect providers to use local guidance (agreed with commissioners) to screen these patient groups.
Numerator	Total number of patients presenting to emergency departments and other units that directly admit emergencies, and acute inpatients services who met the criteria of the local protocol on Early Warning Scores (usually NEWS 2 greater than or equal to 5) (excluding those where an alternative diagnosis is clinically more likely, e.g. major trauma) and were screened for sepsis.
Denominator	Total number of patients presenting to emergency departments and acute inpatient services and other units that directly admit emergencies who were appropriate for screening for Sepsis on the basis of the above-mentioned local protocol.
Rationale for inclusion	The purpose of this CQUIN proposal is to embed a systematic approach towards the prompt identification and appropriate treatment of life-threatening infections, while at the same time reducing the chance of the development of strains of bacteria that are resistant to antibiotics. Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000[7] deaths in England attributed to Sepsis annually. Of these it is estimated that 11,000 could have been prevented. NICE published its first guidance on sepsis in July 2016. The proposed CQUIN is an opportunity for us to encourage provider organisations to follow NICE guidance to improve sepsis management. In 2015/16 there was a national sepsis CQUIN that appears to have raised the rate of screening for sepsis among ED admissions from 52% to 80%, and the rate of

[7] The incidence, and thus mortality figures, for sepsis were revised in late 2015 following the publication into the public domain of HES data by junior minister Ben Gummer. Mortality in England currently sits at approximately 30% according to the 2015 NCEPOD study 'Just say Sepsis' and to ICNARC. This estimated data therefore lead us to a figure of 36,847 lives claimed annually in England.

Indicator 2a	
	prompt antibiotic administration for people in this group with suspected sepsis from 57% in Q3 to 64%. In 2016/17 this CQUIN was extended to also include inpatients who deteriorate due to sepsis. It is too early to yet measure the impact of this; however it has been viewed favourably by clinicians and quality improvement teams who recognise the importance of prompt identification and management of the deteriorating patient as a means of reducing avoidable mortality in hospitals. In addition in 2016/17 there is a CQUIN on antimicrobial resistance (AMR) that aims to reduce both total and inappropriate antibiotic usage in hospitals. This is really important since AMR has increased significantly in recent years and the CMO believes it is a major risk for healthcare; without reversal of the trend we may find we have no drugs to treat serious infections in the future. Both sepsis and AMR CQUINs in 2016/7 include the requirement that a competent clinician reviews the antibiotic prescription within three days of commencement to determine if it is still needed, and if so, if the appropriate antibiotic is being used. The teams working on sepsis and on AMR in NHS England and NHS Improvement believe that the issues of sepsis and AMR are complementary and that developing and implementing a joint CQUIN will support a coherent approach within provider organisations, towards reducing the impact of serious infections. NICE Sepsis: recognition, diagnosis and early management guideline 2016 states that antibiotic prescriptions should be reviewed once microbiology results are available. Evidence has shown that timely antibiotic reviews are associated with lower mortality in patients diagnosed with sepsis[1]. In December 2017, NHS England and NHS Improvement jointly endorsed the National Early Warning Score as the standardised EWS protocol for all acute and ambulance settings. Units not already using NEWS 2 are expected to be transitioning to standardised use of NEWS 2 for supporting the screening of patients during 2018/19. This CQUIN will collect data on NEWS 2 usage, and during Q4 (of 2018/19 only) payments for this CQUIN will only be paid if 90% of the screened cases utilised NEWS 2 (where it is appropriate to use NEWS 2). 1. Garnacho-Montero *et al*, De-escalation of empirical therapy is associated with lower mortality in patients with severe sepsis and septic shock. Intensive care Medicine; 2014; Jan;40(1): 32-40.

Indicator 2a	
Data source	A minimum of 50 records per month after exclusions for ED and a separate 50 minimum after exclusions for Inpatients. Records to denote whether NEWS 2, other EWS or no protocol, was used in initial screening of patient
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	**Year 1** - Q4 2016/17 **Year 2** - Q4 2017/18
Baseline value	See section on payments.
Final indicator period/date (on which payment is based)	See section on payments.
Final indicator value (payment threshold)	See section on payments below for full information. Screening – national thresholds have been set for payment based on absolute performance levels.
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Yes – see payment section below.
Final indicator reporting date	**Year 1** - As soon as possible after Q4 2017/18. **Year 2** - As soon as possible after Q4 2018/19.
Are there rules for any agreed in-year milestones that result in payment?	Yes – see payment section below.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see payment section below.
EXIT Route	To be determined locally.

Rules for in-year payments for indicator 2a in 17/18 and 18/19

Emergency Department and Acute Inpatient Settings

2017/18

Quarter	Timely identification and screening	
Q1	Payment based on % of eligible patients (based on local protocol) screened:	
	Less than 50.0%:	No payment
	50.0%-89.9%:	10%
	90.0% or above:	25%
Q2	As Q1	
Q3	As Q1	
Q4	As Q1	
Full year – % of indicator weighting available	**(max)**	

2018/19

Quarter	Timely identification and screening	
Q1	Payment based on % of eligible patients (based on local protocol) screened:	
	Less than 50.0%:	No payment
	50.0%-89.9%:	10%
	90.0% or above:	25%
Q2	As Q1	
Q3	As Q1	
Q4	As Q1, but payment only made if 90% of screened cases used the NEWS 2 as part of sepsis screening*	
Full year – % of indicator weighting available	**(max)**	

*This change is for consistency with the sepsis implementation guidance and best available evidence. The 'screening for sepsis' involves a senior clinical decision-maker using their judgement to decide if it's likely that the patient has sepsis, and if so to start sepsis treatment.

Supporting Guidance and References

Key Components of Local Protocols

NHSE have published Sepsis guidance implementation advice for adults that includes an operational definition, to facilitate the prompt identification of patients at high risk of having sepsis.

https://www.england.nhs.uk/publication/sepsis-guidance-implementation-advice-for-adults/

Following the publication of the NICE guidance in 2016 on *Sepsis: recognition, diagnosis and early management* [NG51] providers should ensure their protocols follow this guidance.

https://www.nice.org.uk/guidance/ng51

NHSE and NHSI have endorsed use of the RCP's National Early Warning Score as the standard screening system for use in acute and ambulatory settings.

Further detail on use of NEWS 2 can be found at
https://www.england.nhs.uk/nationalearlywarningscore/
https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2
Providers should be mindful of the tools to support screening and management of Sepsis for those not eligible for NEWS 2 at http://sepsistrust.org/clinical-toolkit

Method for identifying random samples

Trusts should select ONE of the following methods and maintain this method throughout the 2017/18 year of data collection:

1. True randomisation: review the nth patient's notes where n is generated by a random number generator or table (eg http://www.random.org/) and this is repeated until a full sample of notes has been reviewed. These are easy to use and readily available online – eg http://www.random.org/

2. Pseudo-randomisation: Review the first X patients' notes where the day within the date of birth is based on some sequence e.g. start with patients born on the 1st of the month, move to 2nd, then 3rd, until X patients have been reviewed. X equals the sample size required. Note this must NOT be based on full birthdate as this would skew the sample to particular age groups.

This should be repeated in 2018/19.

Suggested Format for Local Data Collection

Sepsis Screening in Emergency Departments

nb These could be separately collated for adults and for children and then stated as a final total (although also setting out the adult and child totals).

	Tick column below if the patient DID NOT NEED sepsis screening according to the local protocol	Tick column below if the patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening	Tick column below if the patient NEEDED sepsis screening according to the local protocol but DID NOT receive sepsis screening	Tick column below if patient eligible for NEWS 2 screening	Tick column below if NEWS 2 used (usually greater than or equal to 5)	Tick column below if other NEWS 1 or other EWS used
1.						
2.						
3.						
4.						
5.						
Etc.						
Totals	**Column A total**	**Column B total**	**Column C total**	**Column D**	**Column E total**	**Column F total**
CQUIN calculation **For 2017/18 and Q1 – Q3 2018/19** Column A total is discarded from the sample and does not count towards numerator or denominator Column B total is the numerator total [Column B total + Column C total] = denominator total Percentage Part 1 (sepsis screening) CQUIN achievement = (B ÷ [B+C]) x 100 **For Q4 2018/19 only** The calculation has two parts (Part A and Part B) Part A: Column A total is discarded from the sample and does not count towards numerator or denominator Column B total is the numerator total [Column B total + Column C total] = denominator total Percentage (sepsis screening) = (B ÷ [B+C]) x 100 **Achievement must be at least 90% to proceed**						

to Part B of the calculation. Part B Column D total is the denominator total Column E total is the numerator total Percentage Part 2 (sepsis screening with NEWS 2 used) = (Column E / Column D) x 100 Payment of CQUIN achievement is only made if column E numerator total is greater than or equal to 90% of column D denominator total.			

Sepsis Screening in Inpatient Services

nb These could be separately collated for adults and for children and then stated as a final total (although also setting out the adult and child totals).

	Tick column below if the patient DID NOT NEED sepsis screening according to the local protocol	**Tick column below if the patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening**	**Tick column below if the patient NEEDED sepsis screening according to the local protocol but DID NOT receive sepsis screening**	**Tick column below if patient eligible for NEWS 2 screening**	**Tick column below if NEWS 2 used (usually greater than or equal to 5)**	**Tick column below if NEWS 1 or other EWS used**
1.						
2.						
3.						
4.						
5.						
Etc.						
Totals	**Column A total**	**Column B total**	**Column C total**	**Column D**	**Column E total**	**Column F total**
CQUIN calculation **For 2017/18 and Q1 -Q3 2018/19** Column A total is discarded from the sample and does not count towards numerator or denominator Column B total is the numerator total [Column B total + Column C total] = denominator total Percentage Part 1 (sepsis screening) CQUIN achievement = (B ÷ [B+C]) x 100 **For Q4 2018/19 only**						

Column A total is discarded from the sample and does not count towards numerator or denominator Column B total is the numerator total [Column B total + Column C total] = denominator total Percentage Part 1 (sepsis screening) CQUIN achievement = (B ÷ [B+C]) x 100 **For Q4 2018/19 only** The calculation has two parts (Part A and Part B) Part A: Column A total is discarded from the sample and does not count towards numerator or denominator Column B total is the numerator total [Column B total + Column C total] = denominator total Percentage (sepsis screening) = (B ÷ [B+C]) x 100 **Achievement must be at least 90% to proceed to Part B of the calculation.** Part B Column D total is the denominator total Column E total is the numerator total Percentage Part 2 (sepsis screening with NEWS 2 used) = (Column E / Column D) x 100 Payment of CQUIN achievement is only made if column E numerator total is greater than or equal to 90% of column D denominator total.			

Indicator 2b Timely treatment of sepsis in emergency departments and acute inpatient settings

Indicator 2b	
Indicator name	Timely treatment of sepsis in emergency departments and acute inpatient settings
Indicator weighting (% of CQUIN scheme available)	25% of 0.25% (0.625%)
Description of indicator	The percentage of patients who had suspected sepsis in sample 2a and received IV antibiotics within 1 hour. This timing starts from when the clinical decision maker has decided the patient has suspected sepsis, and stops when effective antibiotics have been administered. The indicator applies to adults and child patients arriving in hospital as emergency admissions and to all patients on acute in-patient wards.
Numerator	Total number of patients found to have suspected sepsis in emergency departments and acute inpatient services in sample 2a who received IV antibiotics within 1 hour of this diagnosis.
Denominator	The total number of patients from the sample in the numerator in 2a who were diagnosed with suspected sepsis.
Rationale for inclusion	Prompt treatment of suspected sepsis reduces the mortality and the morbidity associated with this condition.
Data source	The records identified in the numerator of sample 2a
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	**Year 1** - Q4 2016/17 **Year 2** – Q4 2017/18
Baseline value	See section on payments
Final indicator period/date (on which payment is based)	See section on payments
Final indicator value (payment threshold)	See section on payments below for full information Screening – national thresholds have been set for payment based on absolute performance levels.
Rules for calculation of payment due at	Yes – see payment section below

Indicator 2b	
final indicator period/date (including evidence to be supplied to commissioner)	
Final indicator reporting date	**Year 1** - As soon as possible after Q4 2017/18 **Year 2** - As soon as possible after Q4 2017/18
Are there rules for any agreed in-year milestones that result in payment?	Yes – see payment section below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see payment section below
EXIT Route	To be determined locally

Rules for in-year payments for indicator 2b in 17/18 and 18/19

Emergency Department and Acute Inpatient Settings

Quarter	Timely treatment	
Q1	Payment based on % of patients with sepsis treated within 1 hour (based on those identified in sample 2a)	
	Less than 50.0%:	No payment
	50.0%-89.9%:	10%
	90.0% or above:	25%
Q2	As Q1	
Q3	As Q1	
Q4	As Q1	
Full year – % of indicator weighting available		**(max)**

Supporting Guidance and References

Key Components of Local Protocols

NHSE have published Sepsis guidance implementation advice for adults that includes an operational definition, to facilitate the prompt identification of patients at high risk of having sepsis.
https://www.england.nhs.uk/publication/sepsis-guidance-implementation-advice-for-adults/

Following the publication of the NICE guidance in 2016 on *Sepsis: recognition, diagnosis and early management* [NG51] providers should ensure their protocols follow this guidance.
https://www.nice.org.uk/guidance/ng51

Providers should be mindful of the tools to support screening and management of Sepsis at http://sepsistrust.org/clinical-toolkit

Appropriate tools for sepsis screening

Tools used should be either those produced in conjunction with relevant professional bodies at: http://sepsistrust.org/clinical-toolkit or equivalents that conform to the International Consensus Definitions modified by the Surviving Sepsis Campaign on recognition and diagnosis of sepsis available at http://ccforum.com/content/supplementary/cc11895-s2.pdf.

There are other examples of tools for suitable use in inpatient services at: http://sepsistrust.org/professional/professional-resources/.

Suggested Format for Local Data Collection

Sepsis treatment in Emergency Departments and acute inpatient settings

nb These could be separately collated for adults and for children and then stated as a final total (although also setting out the adult and child totals)
This table can be combined with the tables in indicator 2a.

	Tick column below if the patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening	Tick column below if the patient was diagnosed with sepsis and received IV antibiotics within 1 hour of diagnosis	Tick column below if the patient was diagnosed with sepsis and did not receive IV antibiotics within 1 hour of diagnosis
1.			
2.			
3.			
4.			
5.			
Etc.			
Totals	**Column A total**	**Column B total**	**Column C total**
CQUIN calculation Column A total is discarded from the sample and does not count towards numerator or denominator Column B total is the numerator total [Column B total + Column C total] = denominator total Percentage Part 1 (sepsis treatment) CQUIN achievement = (B ÷ [B+C]) x 100			

Indicator 2c Antibiotic review

Indicator 2c	
Indicator name	Assessment of a clinical **antibiotic review** between 24-72 hours of initiation in patients with sepsis who are still inpatients at 72 hours following the review criteria below.
Indicator weighting (% of CQUIN scheme available)	25% of 0.25% (0.0625%).
Description of indicator	**Year 1** Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours. Appropriate clinical review by either: • Infection (infectious diseases/ clinical microbiologist) senior doctor • Infection pharmacist • Senior member of clinical team With the proportions of antibiotic outcomes in each group submitted, assessed by the following parameters: started on sepsis antibiotic treatment pathway and alive and still an / in-patients at time of review: • If no blood cultures were sent or blood cultures negative at 24-72 hours, a clinical review documenting why antibiotics need to be continued by describing the clinical syndrome, antibiotic choice based on syndrome, local IV to oral switch guidelines, and duration defined • If blood cultures were sent and positive by 24-72 hours, clinical review should document these results, ensure the narrowest spectrum antibiotic treatment is prescribed following local IV to oral switch guidelines AND duration defined. It would be expected that the documented outcome of this review will be recorded as follows: • Stop • IV to oral switch • OPAT (Outpatient Parenteral Antibiotic Therapy) • Continue with new review date • Continue no new review date • Change antibiotic with Escalation to broader

Indicator 2c	
	spectrum antibiotic • Change antibiotic with de-escalation to a narrower spectrum antibiotic Change antibiotic e.g. to narrower/broader spectrum or as a result of blood culture results **Year 2** Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours meeting the following three criteria below: 1. Appropriate clinical review by either: • Infection (infectious diseases/clinical microbiologist) senior doctor (ST3 or above) • Infection pharmacist • Senior member of clinical team (ST3 or above) 2. Documented outcome of review recorded as one of the following 7 options: • Stop • IV to oral switch with a documented review date or duration of the oral antibiotic • OPAT (Outpatient Parenteral Antibiotic Therapy) • Continue with new review date or duration • Change antibiotic with escalation to broader spectrum antibiotic with a documented review date or duration • Change antibiotic with de-escalation to a narrower spectrum antibiotic with a documented review date or duration • Change antibiotic e.g. to narrower/broader spectrum based on blood culture results with a documented review date or duration 3. Where appropriate an IV to oral switch decision was made. If the decision was for the patient to remain on IV antibiotics, a documented rationale for not switching is clearly documented: • Patient is nil by mouth or not absorbing • No oral antibiotic option available • Patient not clinically improving • Deep seated infection • Based on microbiology/ID consultant/Infection Pharmacist advice Data collection forms must be submitted to PHE. A

Indicator 2c	
	random selection of 10% of Trusts data may be used for validation.
Numerator	**Year 1** Number of antibiotic prescriptions reviewed within 72 hours **Year 2** Number of antibiotic prescriptions reviewed between 24 to 72 hours of initiation in patients diagnosed with sepsis that meet the criteria above (i.e. by an appropriate clinician PLUS one of the seven documented outcomes PLUS an IV to oral switch assessment).
Denominator	Number of antibiotic prescriptions included in the sample.
Rationale for inclusion	Rationale is as per part 2a
Data source	Local audit of a minimum of 30 patients diagnosed with sepsis. Audit data and data collection tool should be submitted to PHE via an online submission portal.
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	**Year 1** - Based on achievement in each quarter within 2017/18 **Year 2** - Based on achievement in each quarter within 2018/19
Final indicator value (payment threshold)	**Year 1**- Based on achievement in each quarter within 2018/19 - see milestones section **Year 2** - Based on achievement in each quarter within 2018/19 - see milestones section
Final indicator reporting date	**Year 1** - As soon as possible after Q4 2017/18 **Year 2** - As soon as possible after Q4 2018/19
Are there rules for any agreed in-year milestones that result in payment?	Yes, see milestones section
Are there any rules for partial achievement of the	No

Indicator 2c	
indicator at the final indicator period/date?	
EXIT Route	To be determined locally

Milestones for indicator 2c

Year 1 - 17/18 milestones

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Perform an empiric review for at least 25% of cases in the sample	End Q1	25% of 0.0625% (0.015625%)
Quarter 2	Perform an empiric review for at least 50% of cases in the sample	End Q2	25% of 0.0625% (0.015625%)
Quarter 3	Perform an empiric review for at least 75% of cases in the sample	End Q3	25% of 0.0625% (0.015625%)
Quarter 4	Perform an empiric review for at least 90% of cases in the sample	End Q4	25% of 0.0625% (0.015625%)

Year 2 - 18/19 milestones

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Perform an antibiotic review that meets the criteria above (i.e. by an appropriate clinician PLUS one of the seven documented outcomes PLUS an IV to oral switch assessment) for at least 25% of cases of antibiotic prescriptions.	End Q1	25% of 0.0625% (0.015625%)
Quarter 2	Perform an antibiotic review that meets the criteria above (i.e. by an appropriate clinician PLUS one of the seven documented outcomes PLUS an IV to oral switch assessment) for at least 50% of	End Q2	25% of 0.0625% (0.015625%)

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	cases of antibiotic prescriptions.		
Quarter 3	Perform an antibiotic review that meets the criteria above (i.e. by an appropriate clinician PLUS one of the seven documented outcomes PLUS an IV to oral switch assessment) for at least 75% of cases of antibiotic prescriptions.	End Q3	25% of 0.0625% (0.015625%)
Quarter 4	Perform an antibiotic review that meets the criteria above (i.e. by an appropriate clinician PLUS one of the seven documented outcomes PLUS an IV to oral switch assessment) for at least 90% of cases of antibiotic prescriptions.	End Q4	25% of 0.0625% (0.015625%)

Indicator 2d Reduction in antibiotic consumption per 1,000 admissions and proportion of board spectrum antibiotic use

NB: For 18/19, the 17/18 indicator for reducing the use of piperacillin-tazobactam per 1,000 admissions has been replaced with an indicator on the Access group of the AWaRe* category.

Indicator 2d	
Indicator name for 17/18	Reduction in antibiotic consumption per 1,000 admissions
Indicator name for 18/19	Reduction in antibiotic consumption (DDDs per 1,000 admissions) and increase the proportion of antibiotic usage (for both in-patients and out-patients) within the Access group of the AWaRe* category
Indicator weighting (% of CQUIN scheme available)	25% of 0.25% (0.0625%)
Description of Indicator for 17/18	There are three parts to this indicator. 1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions
Description of Indicator for 18/19	There are three parts to this indicator. 1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions. 2. Total usage (for both in-patients and out-patients) of carbapenems per 1,000 admissions. 3. Increase the proportion of antibiotic usage (for both in-patients and out-patients) within the Access group of the AWaRe* category.
Numerator for 17/18	Total antibiotic consumption as measured by Defined Daily Dose (DDD) Total consumption of carbapenem as measured by Defined Daily Dose (DDD) Total consumption of piperacillin-tazobactam as measured by Defined Daily Dose (DDD)
Numerator for 18/19	1. Total antibiotic consumption as measured by Defined Daily Dose (DDD) 2. Total consumption of carbapenems as measured by Defined Daily Dose (DDD) 3. Antibiotic consumption within the Access group of the AWaRe* category
Denominator for 17/18	Total admissions divided by 1,000

Indicator 2d	
Denominator for 18/19	• For indicators 1 & 2: Total admissions divided by 1,000. • For indicator 3: Total antibiotic consumption.
Rationale for inclusion	Rationale is as per part 2a and 2b
Data source	Acute trusts would submit their own antibiotic consumption data to PHE with admission statistics taken from Hospital Episode Statistics (HES). Antibiotic consumption data would be available for commissioners to review via AMR Fingertips.
Frequency of data collection	Antibiotic consumption data should be submitted quarterly to PHE.
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Annual
Baseline period/date for 2017/18	January 2016-December 2016
Baseline period/date for 2018/19	January 2016-December 2016 minus 1% or 2% (2017/18 targets published)
Baseline value	As per the validated prescription data in 2016
Final indicator period/date (on which payment is based)	Year 1 - 2017/19 Year 2 - 2018/19
Final indicator value for 17/18 (payment threshold)	Each of the indicators is worth 33% of part d Reductions would be required as follows: 1% reduction for those trusts with 2016 consumption indicators below 2013/14 median value, or 2% reduction for those trusts with 2016 consumption indicators above 2013/14 median value
Final indicator value for 18/19 (payment threshold)	Each indicator is worth 33% of part d and the relevant thresholds are detailed below. 1.Reductions for total antibiotics would be as follows: • Trusts that met their 2017/18 target are required to achieve a reduction of 1% against their 2017/18 target (or not increase if already achieved) • Trusts that did not meet their 2017/18 target

Indicator 2d	
	are required to achieve a reduction of 2% against their 2017/18 target (or not increase if already achieved) (i.e. if 17/18 target was not met, the hospital would have to reduce total antibiotic consumption by 2% or more in 18/19) 2.Reductions for carbapenems would be as follows: • Trusts that met their 2017/18 target are required to achieve a reduction of 2% against their 2017/18 target (or not increase if already achieved) • Trusts that did not meet their 2017/18 target are required to achieve a reduction of 3% against their 2017/18 target (or not increase if already achieved) (i.e. if 17/18 target was not met, the hospital would have to reduce carbapenem consumption by 3% or more in 18/19) 3.Increase the proportion of antibiotic usage within the Access group of the AWaRe* category: • Access group ≥55% of total antibiotic consumption (as DDD/1000adm) OR • Increase by 3 percentage points from baseline 2016 calendar year. The Access group includes the following antibiotics: ○ Phenoxymethylpenicillin ○ Nitrofurantoin ○ Metronidazole ○ Gentamicin ○ Flucloxacillin ○ Doxycycline ○ Co-trimoxazole ○ Amoxicillin ○ Ampicillin ○ Benzylpenicillin ○ Benzathine Benzylpenicillin ○ Procaine Benzylpenicillin ○ Oral Fosfomycin ○ Fusidic Acid (sodium fusidate) ○ Pivmecillinam ○ Tetracycline ○ Trimethoprim TB drugs are excluded.
Final indicator reporting date	Year 1 - As soon as possible after Q4 2017/18 Year 2 - As soon as possible after Q4 2018/19
Are there rules for any	No

Indicator 2d	
agreed in-year milestones that result in payment?	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No
EXIT Route	To be determined locally

*Further information regarding the AWaRe categories can be found in the NHS Improvement FAQs

3. Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI)

There are two parts to this CQUIN indicator.

National CQUIN	Indicator	Indicator weighting (% of CQUIN scheme available)
CQUIN 3a	Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment for patients with psychoses	80% of 0.25% (0.20%)
CQUIN 3b	Improving physical healthcare to reduce premature mortality in people with SMI: Collaborating with primary care clinicians	20% of 0.25% (0.05%)

Indicator 3a Cardio metabolic assessment and treatment for patients with psychoses

Indicator 3a	
Indicator name	Cardio metabolic assessment and treatment for patients with psychoses.
Indicator weighting (% of CQUIN scheme available)	80% of 0.25% (0.20%)
Description of Indicator	**For 2017/18** To demonstrate cardio metabolic assessment and treatment for patients with psychoses in the following areas: a) Inpatient wards. b) All community based mental health services for people with mental illness (patients on CPA), excluding EIP services. c) Early intervention in psychosis (EIP) services. **And in addition, for 2018/19** To demonstrate positive outcomes in relation to BMI and smoking cessation for patients in early intervention

Indicator 3a	
	in psychosis (EIP) services.
Numerator	**For 2017/18** The number of patients in the defined audit sample who have both: i. a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's electronic care record held by the secondary care provider. ii. a record of interventions offered where indicated, for patients who are identified as at risk as per the red zone of the Lester Tool. **For 2018/19** For **inpatient wards** and **community mental health services** same as for 2017/18. For **early intervention in psychosis** services, same as for 2017/18 **plus** • **EIP BMI outcome indicator** The number of patients in the defined audit sample who have not exceeded a 7% weight gain since their baseline weight measurement prior to starting on anti-psychotic medication. • **EIP Smoking cessation outcome indicator** The number of patients in the defined audit sample who have stopped smoking.
Denominator	**For 2017/18** **Inpatients** The sample must be limited to patients who have been admitted to the ward for at least 7 days. Inpatients with an admission of less than 7 days are excluded. **Patients on CPA in all community based mental health services** The sample must be limited to patients who have been on the team caseload for a minimum of 12 months. **Early intervention in psychosis services** The sample must be as per the annual CCQI EIP

Indicator 3a	
	Network self-assessment specification. *As per Implementing the Five Year Forward View for Mental Health (https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf) the NHS England planning guidance (https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf) and the NHSI Single Oversight Framework (https://improvement.nhs.uk/uploads/documents/Single_Oversight_Framework_published_30_September_2016.pdf), all EIP services are expected to take part in the EIP Network, a quality assessment and improvement scheme administered by the Royal College of Psychiatrists College Centre for Quality Improvement, CCQI (http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/earlyinterventionpsychosis.aspx). This includes specific review of the quality of physical health care provided to people on the EIP caseload in line with the requirements of this CQUIN scheme.* **For 2018/19** For **inpatient wards** and **community mental health services** same as for 2017/18. For **early intervention in psychosis** services, same as for 2017/18 **plus** • **EIP BMI outcome indicator** The number of patients experiencing a first episode of psychosis (not those classed as having an At Risk Mental State) identified in the 2017/18 sample who have been taking anti-psychotic medication for between at least 6 and 12 months. • **EIP Smoking cessation outcome indicator** The sample must be limited to patients who were identified in the 2017/18 sample as being at risk as per the red zone of the Lester Tool for smoking.
Rationale for inclusion	**Background** People with severe mental illness (SMI) are at increased risk of poor physical health, and their life-expectancy is reduced by an average of 15–20 years

Indicator 3a	
	mainly due to preventable physical illness. Two thirds of these deaths are from avoidable physical illnesses including heart disease and cancer, mainly caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital receive the recommended assessment of cardiovascular risk in the previous 12 months. People with SMI are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency, suggesting deficiencies in the primary physical healthcare they are receiving. <u>Early Intervention in Psychosis Services</u> Since 1 April 2016, the access and waiting time standard for early intervention in psychosis (EIP) services has required that more than 50% of people experiencing first episode psychosis commence treatment with a NICE-approved care package within two weeks of referral. The standard is targeted at people aged 14-65 in line with NICE recommendations. In response to the recommendation of the Mental Health Taskforce, NHS England has committed to ensuring that, by 2020/21, the standard will be extended to reach at least 60% of people experiencing first episode psychosis. To understand the baseline picture in terms of access to NICE-recommended interventions, NHS England commissioned the Healthcare Quality Improvement Partnership (HQIP) to undertake a baseline audit of EIP service provision. The sampling period spanned the period July 2014 to December 2014 and was published on 5 July 2016. Access to high quality physical healthcare assessment and interventions is one of the key requirements of the NICE Quality Standard but the audit finding was that screening for all seven physical health measures took place in only 22% of cases sampled (range of 0%-82%) and all indicated interventions were offered in only 13% of cases sampled (range of 0-64%). Improving access to high quality physical healthcare in EIP services is particularly crucial to improving longer term physical health care outcomes for people with psychosis and a specific focus on EIP services within this CQUIN scheme is therefore necessary. <u>Physical health SMI CQUIN</u>

Indicator 3a	
	This CQUIN builds on the developments across England over the last 3 years to improve physical health care for people with severe mental illness (SMI) in order to reduce premature mortality in this patient group. The number of cardio metabolic assessments completed and interventions offered substantially increased between 2014/15 and 2015/16 and there was an increase in compliance with the CQUIN requirements. By continuing the CQUIN, providers have an opportunity to continue to build on progress made and ensure systems are in place to embed learning and sustain good practice. The aim is to ensure that patients with SMI receive comprehensive cardio metabolic risk assessments and have access to the necessary treatments/interventions. The results are to be recorded in the patient's electronic care record (held by the secondary mental health provider) and shared appropriately with the patient, the treating clinical team and partners in primary care. Patients with SMI for the purpose of this CQUIN are all patients with psychosis, including schizophrenia (see additional notes below), in all types of inpatient units and community settings commissioned from all sectors. The cardio metabolic parameters, based on the Lester Tool, for this CQUIN are as follows: • Smoking status; • Lifestyle (including exercise, diet alcohol and drugs); • Body Mass Index; • Blood pressure; • Glucose regulation (preferably HbA1c or fasting plasma glucose. Random plasma glucose as appropriate); • Blood lipids. Previously EIP services were audited in the PSMI CQUIN. With the access and waiting time standard and subsequent work, as of 2016/17 EIP services are required to complete an annual self-assessment tool (http://www.rcpsych.ac.uk/pdf/EIPN%20Self%20Assessment%20Tool.pdf) which includes completing a physical health review at start of treatment (baseline), at 3 months and then annually (or 6 monthly for young people) unless a physical abnormality arises. This

Indicator 3a	
	includes the cardio metabolic parameters based within the Lester Tool. With data already collected through the CCQI EIP self-assessment tool, the CQUIN will draw upon this information to help calculate the CQUIN indicator above for 2017/18 and 2018/19. <u>BMI and smoking outcomes in EIP services</u> In order to provide stretch upon the previous year's requirements, for 2018/19 this CQUIN scheme will develop to include a focus upon achieving outcomes in relation to BMI and smoking rates within EIP services. These are two of the parameters that, if positively impacted, have most potential to reduce premature mortality. • The BMI outcome indicator is applicable to EIP services where 35% or more patients should gain no more than 7% body weight in the first year of taking antipsychotic medication. • The smoking outcome indicator is applicable to EIP services where 10% or more patients who were previously identified as in the Red Zone for smoking on the Lester Tool should have stopped smoking. This CQUIN is part of a suite of incentives that trusts will be working with, and a number of these incentives will be complementary. The Preventing ill health by risky behaviours – alcohol and tobacco CQUIN indicator also includes a requirement for clinicians to undertake assessment and arrange for intervention where appropriate in relation to smoking status and alcohol use. NHS England and Public Health England have taken steps to ensure alignment between the CQUIN indicators and so this presents an opportunity for providers to build on the practice incentivised through this indicator. It is therefore expected that providers will develop synergies across their work in delivering CQUINs to maximise the opportunities and reduce cost duplication and strengthen efforts in this area.
Data source	Internal mental health provider sample submitted to national audit provider for the CQUIN (for inpatient and community mental health services). Internal mental health provider sample submitted to the Royal College of Psychiatrists CCQI EIP Network (for EIP services).

Indicator 3a	
	Local direct reporting to commissioners
Frequency of data collection	Annual
Organisation responsible for data collection	Mental health provider
Frequency of reporting to commissioner	Results of national audit and EIP quality assessment expected to be available by Quarter 4 for reporting to commissioners (2017/18 and 2018/19). Additional direct reporting to commissioners locally in Quarters 2, 3 and 4.
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	Data for national audit of inpatient and community based mental health services expected to be collected and submitted to national audit provider during Quarter 3 of both 2017/18 and 2018/19. Results to be available in Quarter 4. Data for EIP services expected to be collected and submitted to CCQI during Quarter 2 of both 2017/18 and 2018/19. Results to be available by Quarter 4.
Final indicator value (payment threshold)	**Thresholds for payment:** **For 2017/18** a) Inpatients – 90% b) Community mental health services (patients on CPA) - 65% c) Early intervention in psychosis services – 90% **For 2018/19** a) Inpatients – 90% b) Community mental health services (patients on CPA) - 75% c) Early intervention in psychosis services – 90% BMI outcome indicator – 35% Smoking outcome indicator – 10%
Final indicator reporting date	30 March 2018 and 29 March 2019
Are there rules for	Yes - see below

Indicator 3a	
any agreed in-year milestones that result in payment?	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes - see below (excludes BMI and smoking outcome indicators)

Milestones for indicator 3a

2017/18

Date/period milestone relates to 2017/18	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1 2017/18	i. Ensure sustainable and high quality training programme in place for all relevant clinical staff caring for people with SMI. Training should cover processes for assessing, documenting and acting on cardio metabolic risk factors. Clinical staff training plan should have been fully implemented and all relevant clinical staff trained by the end of Q1. (Assessed locally by commissioners) ii. Ensure clear pathways for interventions and signposting for all cardio-metabolic risk factors: • Smoking cessation • Lifestyle (including exercise, diet alcohol and drugs) • Obesity • Hypertension • Diabetes • High cholesterol Clear pathways should be in place and have been	July 2017	30% of indicator weighting for part 3a (10% for each of I, ii and iii).

Date/period milestone relates to 2017/18	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	disseminated to all clinical teams by the end of Q1. (Assessed locally by commissioners) iii. Ensure that the electronic care record system has been developed and is being used effectively for collection of physical health assessment and interventions data. (Assessed locally by commissioners).		
Quarter 4 2017/18	Results of national audit across inpatient and community mental health services and of EIP self-assessment scheme published. (See sliding scales below for payment details). Evidence of systematic feedback on performance to clinical teams (Assessed locally by commissioners).	April 2018	70% of indicator weighting for part 3a, made up of: 20% (Inpatient services) 20% (EIP services) 30% (Community teams)

2018/19

Date/period milestone relates to 2018/19	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1 2018/19	i. Ensure physical health training programme is built into mandatory training procedures and: • All staff who should have been trained have received initial training	July 2018	10% of indicator weighting for part 3a

Date/period milestone relates to 2018/19	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	• New starters in relevant roles are trained • Relevant staff receive refresher training ii. Continue to ensure clear pathways for interventions and signposting for all cardio-metabolic risk factors: • Smoking cessation • Lifestyle (including exercise, diet alcohol and drugs) • Obesity • Hypertension • Diabetes • High cholesterol (Assessed locally by commissioners) iii. Complete internal audit to provide assurance that physical health assessment and interventions data are being recorded appropriately on the electronic care record. (Assessed locally by commissioners).		
Quarter 4 2018/19	Results of national audit across inpatient and community mental health services and of EIP self-assessment scheme published. (See sliding scales below for payment details). Evidence of systematic feedback on performance to clinical teams (Assessed locally by commissioners). Results of audit across EIP services for achieving BMI outcome indicator – at least 35% of patients should gain no more than 7% body weight in the first year of taking antipsychotic medication.	April 2019	90% of indicator weighting for part 3a, made up of: 20% (Inpatient services) 40% (Community teams) 20% (EIP services)

Date/period milestone relates to 2018/19	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	Results of audit across EIP services for achieving EIP smoking outcome indicator – at least 10% of patients who were previously in the Red Zone for smoking on the Lester Tool have stopped smoking.		5% (EIP BMI indicator) 5% (EIP Smoking indicator)

Rules for partial achievement of indicator 3a

Inpatient services & Early Intervention Psychosis Services (excluding BMI and smoking outcome indicators for which there is no partial achievement threshold)

For 2017/18 and 2018/19

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
49.9% or less	No payment
50.0% to 69.9%	25% payment
70.0% to 79.9%	50% payment
80.0% to 89.9%	75% payment
90.0% or above	100% payment

Community Mental Health Services

For 2017/18

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
34.9% or less	No payment
35.0% to 44.9%	25% payment
45.0% to 54.9%	50% payment
55.0% to 64.9%	75% payment
65.0% or above	100% payment

For 2018/19

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
44.9% or less	No payment
45.0% to 54.9%	25% payment
55.0% to 64.9%	50% payment

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
65.0% to 74.9%	75% payment
75.0% or above	100% payment

Indicator 3b Collaboration with primary care clinicians

Indicator 3b	
Indicator name	Collaboration with primary care clinicians.
Indicator weighting (% of CQUIN scheme available)	20% of 0.25% (0.05%)
Description of Indicator	90% of patients to have either, an up to date Care Programme Approach (CPA), Care Plan or a comprehensive discharge summary shared with their GP. A local audit of communications should be completed.
Numerator	The number of patients in the locally defined audit sample for whom the mental health provider has provided to the GP* an up-to-date copy of the patient's care plan/CPA review letter or a discharge summary which sets out details of all of the following: i. NHS number. ii. All primary and secondary mental and physical health diagnoses. iii. Medications prescribed and recommendations (including duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication). iv. Ongoing monitoring and/or treatment needs for cardio-metabolic risk factors identified, as per the Lester Tool. v. Care plan or discharge plan. *To take place within the following time periods: • Within 48 hours for patients discharged as inpatients. • Within 2 weeks for patients on CPA.
Denominator	Patients within the locally defined audit sample who are subject to the CPA and who have been under the care of the mental health provider for at least 12 months at the time of the defined audit period.
Rationale for inclusion	With over 490,000 people with SMI registered with a GP, it is important to ensure a stronger emphasis on collaboration and communication between primary and secondary care. This is necessary given that in the longer term and certainly following discharge from secondary care, people with SMI should be supported to manage their health within primary care.

Indicator 3b	
	Appropriate sharing and exchanging of information between practitioners about diagnosed physical and mental health conditions is essential for safe practice. The rationale for this CQUIN is to ensure essential information needed for safe and effective care of patients who are also seen by secondary care mental health services is communicated to primary care professionals. Building on the developments made across England to improve communications between primary and secondary care, the CQUIN addresses further alignment and collaboration. To do this, responsibilities for conducting physical health checks and the ongoing management of physical healthcare should be clearly identified and formalised locally. Electronic systems and infrastructure should continue to evolve to support the transfer of accurate and up to date patient records, making information accessible. In order to facilitate safe, effective and joined-up care between primary and secondary care teams NHS England has developed guidance to support the commissioning of improved physical health care for people with SMI within a primary care service[8].
Data source	Internal audit undertaken by mental health providers.
Frequency of data collection	Annual audit
Organisation responsible for data collection	Mental health provider
Frequency of reporting to commissioner	Results of local audit required to be reported to local commissioners in Quarter 4 of both 2017/18 and 2018/19.
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	Quarter 3 of both 2017/18 and 2018/19.
Final indicator value (payment threshold)	90.0%
Final indicator reporting date	30 March 2018 and 29 March 2019

[8] https://www.england.nhs.uk/mental-health/resources/smi-toolkit/

Indicator 3b	
Are there rules for any agreed in-year milestones that result in payment?	Yes – see below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see below
EXIT Route	To be determined locally

Milestones for indicator 3b

2017/18

Date/period milestone relates to 2017/18	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 2 2017/18	Identify and develop clear plans for aligning and cross checking SMI QOF and CPA registers.	October 2017	20% of indicator weighting for part 3b
Quarter 3 2017/18	Establish a clear shared care protocol between secondary care provider and primary care regarding physical health checks for people with SMI and the appropriate follow up. This should include information on: • Communication channels locally. • Resources contributed to this agenda. • Roles and responsibilities, including frequency of follow up annual physical health checks. • Sharing and exchanging information regarding physical health of people with SMI, via electronic patient records across secondary and primary interfaces.	December 2017	50% of indicator weighting for part 3b

Date/period milestone relates to 2017/18	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	Audit to be undertaken by provider.		
Quarter 4 2017/18	Results of local audit required to be reported to local commissioners. (See sliding scale below for payment details) Action plan in place for 2018/19 based on audit findings.	April 2018	30% of indicator weighting for part 3b

2018/19

Date/period milestone relates to 2018/19	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1 2018/19	Complete alignment of SMI QOF and CPA registers and have system in place for routine reconciliation going forward	July 2018	20% of indicator weighting for part 3b
Quarter 2 2018/19	Review progress made in implementing shared care protocol between secondary care provider and primary care regarding physical health checks for people with SMI and the appropriate follow up checks. Agree joint action plan to address outstanding issues.	October 2018	50% of indicator weighting for part 3b
Quarter 3 2018/19	Evidence status of interoperability of data and IT systems between secondary and primary care, to facilitate flow of information on physical health issues for people with SMI. Agree joint action plan to address outstanding issues. Audit to be undertaken by	December 2018	10% of indicator weighting for part 3b

Date/period milestone relates to 2018/19	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	provider.		
Quarter 4 2018/19	Results of local audit required to be reported to local commissioners. (See sliding scale below for payment details).	April 2019	20% of indicator weighting for part 3b

Rules for partial achievement of indicator 3b

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
49.9% or less	No payment
50.0% to 69.9%	25% payment
70.0% to 79.9%	50% payment
80.0% to 89.9%	75% payment
90.0% or above	100% payment

Supporting guidance and references for CQUIN 3a and 3b implementation

ICD 10 codes:
For the purposes of the CQUIN, patients who have a diagnosis of psychosis, including schizophrenia and bipolar affective disorder with the relevant ICD-10 diagnostic codes will be included in the national audit: F10.5, F11.5, F12.5, F13.5, F14.5, F15.5, F16.5, F19.5, F20-29, F30.2, F31.2, F31.5, F32.3 and F33.3.

Lester tool:
http://www.rcpsych.ac.uk/pdf/RCP_11049_Positive%20Cardiometabolic%20Health%20chart-%20website.pdf

NICE resources to support implementation:

- NICE guidelines make recommendations about the promotion of physical health in people with psychosis and schizophrenia, and a range of other guidelines are available to improve aspects of physical health including smoking cessation, obesity, glucose regulation, blood lipids, and lifestyle factors.
- Implementation products (such as baseline assessment tools, NICE pathways, online learning modules, and local practice examples) can be found on the “tools and resources” tab of the guideline; for example https://www.nice.org.uk/guidance/cg178/resources, which includes access to the Lester Positive Cardio metabolic Health Resource, endorsed by NICE.

4. Improving services for people with mental health needs who present to A&E

Indicator 4	
Indicator name	Improving services for people with mental health needs who present to A&E.
Indicator weighting (% of CQUIN scheme available)	0.25%
Description of Indicator	**For 2017/18 (year 1):** 1. Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable. **For 2018/19 (year 2):** 1. Where a 20% reduction in attendances to A&E was achieved in year 1 (for those within the selected cohort of frequent attenders) maintain this reduction (i.e. ensure that the total number of attendances of the cohort in 2018/19 is at least 20% less than the baseline in 2016/17). Where a 20% reduction was not achieved for the cohort, to achieve a 20% reduction in A&E attendances from the 16/17 baseline number of attendances. 2. Building on the work in year 1, identify a new cohort of frequent attenders to A&E during 17/18 who could benefit from psychosocial interventions and work to reduce by 20%, their attendances to A&E during 2018/19. In year 2, it is expected that the cohort will include groups who experience particular inequalities in access to mental health care (see below for further detail). Ensure that mental health attendances to A&E are recorded and submitted to the Emergency Care Dataset. This will be done by ensuring that attendances to A&E have a valid chief complaints, diagnosis and injury intent recorded (see supplementary guidance below). **Mental health and acute hospital providers,** working together with other partners (such as primary care, IAPT services, police, ambulance, substance misuse, social care, voluntary sector), to ensure that people presenting at A&E with primary or secondary mental health and/or underlying psychosocial needs have these

Indicator 4	
	needs met more effectively through an improved, integrated community service offer, with the result that attendances at A&E are reduced. The CQUIN has been designed so as to encourage collaboration between providers across the care pathway and as such is to be applied to both acute providers and mental health providers. While it takes account of different responsibilities for providers, performance by both acute and mental health providers will be measured and shared across the pathway, and will affect overall achievement against the CQUIN indicator. All mental health and acute providers subject to the scheme will therefore need to work together to ensure the successful delivery of all milestones and to achieve levels of performance necessary to release full reward. Successful achievement of the CQUIN is therefore likely to necessitate partnership working and joint governance between CCGs, acute providers, mental health providers and other key local partners. Areas may wish to use existing forums such as A&E Delivery Boards and Crisis Care Concordat groups to oversee this process. Where there are a number of providers fulfilling the acute or mental health provider role for a given locality, their contribution to overall performance for that locality should be weighted in line with their respective levels of commissioned activity for that locality. CCGs will need to determine the allocation of the rewards locally, based on their local geographies, taking into account: a) the differing provider geographies (e.g. mental health providers may serve populations across the footprints of varying numbers of A&E departments); b) different arrangements in different areas – for example, some liaison services are provided by mental health trusts and some are provided by acute trusts; and c) the milestones set out in the CQUIN – the achievement of which are contingent on actions from either mental health providers, acute providers, or both working together; CCGs will therefore need to consider and agree with providers the proportion of the indicators for each year that will be delivered by the acute provider(s), what proportion will be delivered by the MH provider(s), and what by both. Year 1 focussed on improving understanding of the complex needs of a small cohort of people who use A&E most intensively. There was a particular focus on identifying those people within the cohort who may benefit from integrated mental

Indicator 4	
	and physical health assessment, care planning and interventions[9]. There was also be an intensive focus on improving the quality of coding of primary and secondary mental health needs in the A&E dataset. Year 2 will seek to maintain the progress of year 1, i.e. where a 20% reduction of attendances for the cohort of frequent attenders was achieved, the total attendances for the group should remain at 20% less than the baseline number. Or where the 20% reduction was not achieved, then this reduction should be achieved (based on the 2016/17 baseline number of attendances). Year 2 will seek to build on the work in year 1 by requiring identification of an additional cohort of frequent attenders. It also includes a requirement to continue implementation of the Emergency Care Dataset with a focus on ensuring that mental health activity is recorded robustly and comprehensively in the new dataset. The original central ambition for year 2: to achieve a reduction in overall mental health attendances - will no longer be possible for the purposes of the CQUIN given that the switch in datasets from HES to ECDS means that in many areas there is no longer a robust baseline level of mental health attendances from which to measure reductions. However, this does not alter the need to focus on investment in out of hospital mental services that can be more suitable way of meeting many people's mental health needs. Funding for community crisis and acute services is set out in CCG baselines as part of the *Five Year Forward View for Mental Health*. **Year 1** 1. Identify the people who attended each A&E most frequently during 2016/17 (this is likely to be people who would usually attend A&E 10-15 times or more; the cohort will need to be adjusted for attrition[10]). 2. Review this group and identify the sub-cohort of people for whom mental health and psychosocial interventions led by specialist mental health staff would have the greatest impact. The number of people in the cohort will need to be agreed locally between providers and commissioners. It is expected that cohorts will include at least 10-15 people per hospital site. However, where

[9] Please see 'rationale' section below for further detail about selection and segmentation of this cohort
[10] E.g. due to deaths, relocations out of area etc.; the approach to accounting for attrition should be defined locally in agreement between commissioners and providers

Indicator 4	
	possible, larger cohorts than this are encouraged as the greater the number of people in the cohort, the greater the potential benefits. For large hospitals serving greater populations, commissioners should seek to include larger cohorts in the scheme. Individual hospitals will have their own systems and methods of identification and this cohort's number of attendances for 2016/17 and number of patients will be recorded to set the baseline; 3. Review and develop a co-produced care plan[11] for each person in this cohort, which includes a focus on preventing avoidable A&E attendances. While a collaborative approach is critical to the successful implementation of this CQUIN scheme, the appointment of a named dedicated clinical lead or leads is likely to be beneficial. Care plans should be made available to A&E departments so that when a named person in the selected cohort does attend A&E, they receive more consistent care that better meets their needs. Care plans should be developed with the individual in question and involve and/or be shared with other relevant partner organisations where appropriate, such as primary care, including as part of the discharge planning process.[12] Consideration should be given to the use of integrated and interoperable electronic care records or the enhanced Summary Care Record as enabling platforms. 4. Strengthen existing / develop new services to support this cohort of people better and offer safe and more therapeutic alternatives to A&E where appropriate. 5. Over one year, reduce by 20% the number of attendances to A&E for those within the selected cohort of frequent attenders, and establish improved services to ensure this reduction is sustainable; 6. Improve the quality of A&E data submission for mental health needs, ensuring that coding for the final quarter of the year is complete and accurate; ensure systems are in place to assure quality of data submission for mental health activity in the Emergency Care Dataset (ECDS)* going forward, including conducting an internal audit of

[11] The care plan may be known by other names, such as an attendance plan or personal support plan. The purpose of the plan is to guide care delivered by staff whenever an identified patient attends A&E, promoting consistency of care that aims to better meet the needs of patients. Involvement of patients and carers in their co-production is essential, and other partner agencies including primary care should be aware of the plans, and have access and contribute to their development as necessary. They should include a patient's key health and care issues and accompanying management plans, and other relevant information such as the different named professionals involved in their care.

[12] Resources are available to support collaborative care planning in line with the requirements of the CQUIN: https://www.rcem.ac.uk/docs/RCEM%20Guidance/CEM6883-Mental%20Health%20in%20ED_Toolkit.pdf; http://www.yhscn.nhs.uk/media/PDFs/mhdn/Mental%20Health/AE%20MH%20CQUIN%20information%20sharing%20-%20final.pdf

Indicator 4	
	recording of mental health activity in A&E to provide assurance of data quality. **Year 2** 1. a) where a 20% reduction of attendances for the cohort of frequent attenders was achieved in year 1, the number of attendances in the group remains at least 20% less than the baseline level in 2016/17; or b) where the 20% reduction was not achieved in 2017/18, then the 20% reduction is achieved (based on the 2016/17 baseline level). 2. Identify a new cohort of people who attended A&E frequently in 2017/18 and achieve 20% reduction in their attendances to A&E in 2018/19 from the baseline level in 2017/18. As a guide, this Year 2 cohort will: (a) include at least 25-30 people. Local areas have the flexibility over the exact size of the cohort, and as in year 1, it is expected that many areas will choose larger cohorts given the greater potential benefits; (b) the new cohort does not necessarily need to be of the *most* frequent attenders to A&E. A local area may for instance, seek to meet the needs of a larger group of people who use A&E less frequently than the cohort in year 1; (c) will focus on groups of people who experience particular inequalities in accessing services, as identified locally.[13] 3. Undertake internal audit of recording of mental health activity in the ECDS, and meet locally agreed thresholds for data quality (further details below). The benefits expected from this CQUIN would be: • Identification of intensive users of local emergency physical and mental health services and improved understanding of their health and care needs and joint review / creation of personalised care plans for this cohort; • Reduced healthcare usage, reducing avoidable pressures on emergency departments and GP services; • Improved health and social outcomes for this cohort; • Improved experience of health and care services for this cohort, including reduced stigma through increased staff education and awareness; • Improved data quality and recording of mental health need in emergency departments; • Improved integrated care pathways across providers, including timely communication and collaboration between acute trusts, mental health providers,

[13] See supplementary notes below regarding inequalities in access

<table>
<tr><th colspan="2">Indicator 4</th></tr>
<tr><td></td><td>ambulance services, primary care, social care, public health (drug/alcohol services) and the voluntary sector; and
• Joint governance and working between various providers will provide a better picture of local needs and demand, which can inform commissioning.</td></tr>
<tr><td>Numerator / Denominator</td><td>For Year 1 (2017/18):

1. Reduce by 20% the number of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable:

$$Indicator = \left[\frac{\text{Number of Accident and Emergency presentations during } 2017-18 \text{ from those within the selected cohort of frequent attenders in } 2016-17 \text{ who would benefit from mental health and psychosocial interventions}}{\text{Number of Accident and Emergency presentations during } 2016-17 \text{ from those within the selected cohort of frequent attenders in } 2016-17 \text{ who would benefit from mental health and psychosocial intereventions (}\mathbf{\text{cohort to be adjusted for attrition}}\text{)}}\right] \times 100\%$$

eg:

$$\left[\frac{150 \text{ presentations in } 2017-18}{200 \text{ presentations in } 2016-17}\right] \times 100\% = 75\% \text{ (i.e. } 25\% \text{ reduction).}$$

For Year 2 (2018/19):

1. a) where a 20% reduction of attendances for the cohort of frequent attenders was achieved in year 1, the number of attendances in the group remains at least 20% less than the baseline level in 2016/17; or b) where the 20% reduction was not achieved in 2017/18, then the 20% reduction is achieved (based on the 2016/17 baseline level). The cohort will need to be adjusted for attrition[14]</td></tr>
</table>

[14] E.g. due to deaths, relocations out of area etc.

Indicator 4	
	$$Indicator = \left[\frac{\text{Number of Accident and Emergency presentations during } 2018-19 \text{ from those within the cohort of frequent attenders in } 2016-17 \text{ who would benefit from mental health and psychosocial interventions}}{\text{Number of Accident and Emergency presentations during } 2016-17 \text{ from those within the selected cohort of frequent attenders in } 2016-17 \text{ who would benefit from mental health and psychosocial intereventions (}\textbf{cohort to be adjusted for attrition}\text{)}} \right] \times 100\%$$ 2. Building on the work in year 1, identify a new cohort of frequent attenders to A&E during 17/18 who could benefit from psychosocial interventions and work to reduce by 20%, their attendances to A&E during 2018/19. $$Indicator = \left[\frac{\text{Number of Accident and Emergency presentations during } 2018-19 \text{ from those within the cohort of frequent attenders in } 2017-18 \text{ who would benefit from mental health and psychosocial interventions}}{\text{Number of Accident and Emergency presentations during } 2017-18 \text{ from those within the selected cohort of frequent attenders in } 2017-18 \text{ who would benefit from mental health and psychosocial intereventions (}\textbf{cohort to be adjusted for attrition}\text{)}} \right] \times 100\%$$
Rationale for inclusion	People with mental ill health are 3 times more likely to present to A&E than the general population. More than 1 million presentations are currently recorded as being directly related to mental ill health. People with known mental ill health are 5 times more likely to be admitted to acute hospitals and 80% of these emergency admissions are recorded as being primarily for physical health reasons. This highlights the need for acute hospitals to be equipped to detect and treat urgent mental health needs that are cited as the primary reason for presentation as well as improving identification of underlying mental health conditions where the primary presenting reason may be a physical health one. The QualityWatch study also found that people with mental ill health had 3.6 times more potentially preventable emergency admissions than those without mental ill health in 2013/14, and that “the high levels of emergency care use by people with mental ill health indicate that they are not having their care well

Indicator 4	
	managed and suggest that there are opportunities for planned care (inside and outside of the hospital) to do more. These people are well known to the healthcare system and are having many health encounters". **Source:** http://www.qualitywatch.org.uk/focus-on/physical-and-mental-health Furthermore, a recent systematic review and meta-analysis of studies in the NHS and comparable health systems suggests that approximately one-third to two-thirds of people who attend A&E due to mental ill health have been known to mental health services. A large majority of the people with the most complex needs who attend A&E the most frequently are likely to have significant health needs including physical and mental co-morbidities, and may benefit from assessment and review of care plans with specialist mental health staff, and further interventions from mental health, primary, community, social care, alcohol and substance misuse, and voluntary sector services. The CQUIN is for all ages – and it is for local areas to determine and segment the needs of the selected patient cohorts. The cohorts of people who could benefit from case management, advance care planning and community interventions to help reduce A&E attendances, might typically include: • People with primary substance misuse problems but with co-morbid mental health and social needs; • People with long-term conditions (e.g. COPD, diabetes, heart failure, chronic pain syndrome) which have a mental health component that has previously been undetected; • Older people with a combination of multiple and deteriorating physical health problems, frailty, cognitive dysfunction and increasing social need; • People with primarily complex mental health needs including self-harming behaviour, personality disorders, substance misuse; • People with medically unexplained symptoms and resultant intensive health-seeking behaviours; and • People with complex social needs, including e.g. housing, domestic violence, loneliness/social isolation, financial difficulties. Nationally, the way A&E activity is recorded in national datasets has meant mental health activity has been significantly under-reported, and the new ECDS provides the opportunity to

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	address this. Further to this, it is often anecdotally reported that people with mental ill health make considerable use of A&E, and staff time, often staying there for long periods due to lack of alternatives (with frequent breaches of the 4hr A&E target) even though it is often not the best setting to meet their needs. Studies, such as those cited above, also point to a considerable amount of undetected underlying mental health need among people presenting primarily for physical health reasons. However, poor data quality means that it has not been possible to reliably quantify the extent of this. It is in the clear interest of acute and mental health providers to improve the quality of data - not only to improve patient outcomes, but also to be able to demonstrate the true prevalence of mental health need in A&E, and make the case for improved services. Central to the CQUIN is the recognition that information sharing practices within the NHS itself and beyond need to improve, particularly for patients with mental health needs, in order to improve their experiences of care and outcomes. The issue of missed opportunities to share information in the interest of patient safety has also been raised by coroners on many different occasions following suicides and other serious incidents, with misplaced concerns about patient confidentiality often cited as a contributory factor. The information sharing practices encouraged by the CQUIN[15] support the Caldicott Review's assertion that the duty to share information can be as important as the duty to protect patient confidentiality, and that health and social care professionals should have the confidence to share information in the best interests of their patients.[16] [17] Information sharing agreements where they are not already in place should be expedited.[18]
Data source	NHS Digital SDCS collection
Frequency of data collection	Quarterly submissions to commissioners relating to milestones set out below. Single annual submission to NHS England via SDCS collection

[15] http://www.yhscn.nhs.uk/media/PDFs/mhdn/Mental%20Health/AE%20MH%20CQUIN%20information%20sharing%20-%20final.pdf

[16] Caldicott review: information governance in the health and care system: https://www.gov.uk/government/publications/the-information-governance-review

[17] NHS England, A Quick Guide to Sharing Patient Information for Urgent & Emergency Care: http://www.nhs.uk/NHSEngland/keogh-review/Documents/160203-qucik-guide-Sharing-Patient-Information-for-Urgent-Care.pdf

[18] The Information Governance Alliance (hosted by NHS Digital) and the Centre of Excellence for Information Sharing have produced helpful resources: http://systems.digital.nhs.uk/infogov/iga/resources/infosharing & http://informationsharing.org.uk/our-work/learning-good-practice/ & http://informationsharing.org.uk/our-work/resources/

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Organisation responsible for data collection	• Acute providers to collect data on cohorts (number of patients, number of attendances). • Quarterly reports to CCGs. • Annual national submission to NHS England.
Frequency of reporting to commissioner	Quarterly
Baseline period/date	2016/17 – for Year 1 cohort 2017/18 – for Year 2 cohort
Baseline value	A&Es to confirm number of people in the selected cohorts and to calculate total number of attendances in 2016/17 and 2017/18 respectively for Year 1 and Year 2 cohorts (including attendances per patient), and submit to NHS England via NHS Digital SDCS.
Final indicator period/date (on which payment is based)	Payment schedule as per milestones below. 2 year CQUIN scheme: • Year 1 payment based on performance during 2017/18. • Year 2 payment based on performance during 2018/19.
Final indicator value (payment threshold)	**Year 1** • 20% reduction in A&E attendances of the selected cohort of frequent attenders to A&E in 2016/17 who would benefit from mental health and psychosocial interventions. **Year 2** • Where a 20% reduction of attendances for the cohort of frequent attenders was achieved in year 1, the number of attendances in the group remains at least 20% less than the baseline level in 2016/17; or where the 20% reduction was not achieved in 2017/18, then the 20% reduction is achieved (based on the 2016/17 baseline level). • 20% reduction in 2018/19 among the new cohort of frequent attenders from the baseline level in 2017/18.
Final indicator reporting date	Q1 2019/20
Are there rules for any agreed in-year milestones that result in payment?	Yes, in the milestones selection below.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes, in the partial achievement section below.

Milestones for indicator 4

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1 2017/18	MH trust and acute trust to review most frequent A&E attenders who have attended 10-15 times or more within the last 12 months (i.e. throughout 2016/17). Local acute and MH providers identify subset of people from most frequent A&E attenders who would benefit from assessment, review, and care planning with specialist mental health staff. Ways in which this can be done could include: • Clinical review meetings between A&E and liaison mental health clinicians; • Opportunistic assessment by liaison mental health clinicians (i.e. at one of the cohort patient's next attendances); • Review of case notes. Once this subset has been identified, the number of patients within it and the number of 2016/17 attendances is recorded to set a baseline. MH trust and acute trust to assure commissioners that further work has been undertaken with partners (111, ambulance service, police, substance misuse, primary care etc) to identify whether identified cohort also presenting frequently at other UEC system touch points.	End Q1 2017/18	10%
Quarter 2	MH trust and acute trust to	End Q2	10%

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
2017/18	work together to identify whether the presentations of the identified cohort were coded appropriately in A&E HES dataset. Conduct internal audit of A&E mental health coding. On the basis of findings, agree joint data quality improvement plan and arrangements for regular sharing of data regarding people attending A&E.	2017/18	
Quarter 2 2017/18	MH trust, acute trust establish joint governance arrangements to review progress against CQUIN and associated service development plans.	End Q2 2017/18	0%
Quarter 2 2017/18	MH trust, acute trust, to work with other key system partners as appropriate/necessary to ensure that: • Care plans (co-produced with the patient and written in the first person) are in place for each patient in the identified cohort of frequent attenders; • A system is in place to identify new frequent attenders and ensure that care plans are put in place swiftly; • Care plans are shared with other key system partners (with the patient's permission).	End Q2 2017/18	10%
Quarter 2 2017/18	MH trust, acute trust, bringing in other local partners as necessary/appropriate, agree service development plan to	End Q2 2017/18	20%

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	support sustained reduction in A&E frequent attendances by people with MH needs. This is likely to include enhancements to: • Primary care mental health services including IAPT; • Liaison mental health services in the acute hospital; • Community mental health services and community-based crisis mental health services; This work is likely to need to be undertaken with other partners outside of the NHS, including social care, public health and voluntary sector partners.		
Quarter 3 2017/18	MH trust, acute trust review progress against data quality improvement plan and all confirm that systems are in place to ensure that coding of MH need via ECDS submissions is complete and accurate, to allow confidence that Q4 submissions are complete and accurate. Assurances provided to CCGs accordingly. Mental health provider, acute provider to agree formally and assure CCG that they are confident that a robust and sustainable system for coding primary and secondary mental health needs is in place.	End Q3 2017/18	10%
Quarter 4 2017/18	20% reduction in A&E attendances of those within the	End Q4 2017/18	40%

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	selected cohort of frequent attenders in 2016/17 that would benefit from mental health and psychosocial interventions.		
Quarter 4 2017/18	Providers will need to submit aggregate data via NHS Digital SDCS to demonstrate performance against the CQUIN in 2017/18. The single end of year national NHS Digital SDCS data submission to NHS England will include: • Total number of A&E attendances of the selected cohort of most frequent attenders in 2016/17 who were identified as potentially benefitting from mental health and psychosocial interventions, and total number of these patients; • Total number of A&E attendances of those within the selected cohort in 2017/18, and total number of these patients; • Confirmation that all 2017/18 milestones (as set out above) have been achieved, signed off by local A&E Delivery Board.	Q1 2018/19	0%
Quarter 1 2018/19	MH trust and acute trust to review frequent attenders during 2017/18 and identify new cohort of frequent attenders who may benefit from psychosocial interventions, in line with guidance above.	End Q1 2018/19	0%

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	Once this cohort has been identified, the number of patients within it and the number of 2017/18 attendances is recorded to set a baseline.		
Quarters 1 and 2 2018/19	Repeat 2017/18 Q2 milestone on care planning and engagement with local partner agencies with aim of: • maintaining / increasing reduction in A&E attendances for the existing cohort • achieve reduction in attendances for the new cohort Ensure local data collections established for cohort to support evaluation CQUIN project, including collection of data on: • patient experience • clinical outcomes • health utilisation (to support economic case)	End Q2 2018/19	10%
Quarter 1 2018/19	Conduct internal review of ECDS A&E mental health coding and data submission. On the basis of findings, agree joint data quality improvement plan, and agree thresholds for ECDS data quality by: (i) end of Q2 and (ii) end Q4 2018/19; as well as arrangements for regular sharing of data between relevant providers regarding people attending A&E with mental health needs.	End Q1 2018/19	0%
Quarters 1	Achieve locally agreed Q2 data	End Q2	10%

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
and 2 2018/19	quality standards for ECDS submissions[19]. See supplementary guidance below for further detail.	2018/19	
Quarter 3 2018/19	MH trust, acute trust review progress against data quality improvement plan and all confirm that systems are in place to ensure that coding of MH need via ECDS submissions is complete and accurate, Assurances provided to CCGs accordingly.	End Q3 2018/19	0%
Quarter 4 2018/19	Achieve locally agreed Q4 data quality standards for ECDS submissions.	End Q4 2018/19	25%
Quarter 4 2018/19	Agree plan to mainstream CQUIN work programme to become business as usual going forward.	End Q4 2018/19	5%
Quarter 4 2018/19	Either: • Where a 20% reduction of attendances for the cohort of frequent attenders was achieved in year 1, the number of attendances in the group remains at least 20% less than the baseline level in 2016/17; OR • Where the 20% reduction was not achieved in 2017/18, then the 20% reduction is achieved (based on the 2016/17 baseline level).	End Q4 2018/19	10%
Quarter 4 2018/19	20% reduction in 2018/19 among the new cohort of frequent attenders from the baseline level in 2017/18	End Q1 2019/20	40%
Quarter 4 2018/19	National data submission to NHS England via NHS Digital	Q1 2019/20	0%

[19] The improvement in data quality in year 2 should be in line with locally agreed data standards. Locally agreed data quality standards should include, but are not limited to, percentage coverage of fields such as Chief Complaint, Diagnosis and relevant Injury Intent data.

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	SDCS for: • total number of A&E attendances for frequent attenders who would benefit from mental health and psychosocial interventions during 2017/18 (baseline for new cohort), and number of people in cohort • total number of A&E attendances for frequent attenders who would benefit from mental health and psychosocial interventions during 2018/19 for those within both cohorts and number of people in each cohort. • Confirmation that all 2018/19 milestones have been met, agreed by local A&E Delivery Board.		

Rules for partial achievement of indicator 4

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
Year 1 – 15-19.99% reduction in A&E attendances of those within the selected cohort of frequent attenders in 2016/17 who would benefit from mental health and psychosocial interventions.	30% (maximum available is 40% for achieving 20%+ reduction)
Year 1 – 10-14.99% reduction in A&E attendances of the selected cohort of frequent attenders in 2016/17 who would benefit from mental health and psychosocial interventions.	20%
Year 1 – 5-9.99% reduction in A&E attendances of the selected cohort of frequent attenders in 2016/17 who would benefit from	10%

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
mental health and psychosocial interventions.	
Year 2 – 15-19.99% reduction in A&E attendances of those within the selected cohort of frequent attenders in 2017/18 who would benefit from mental health and psychosocial interventions.	30% (maximum available is 40% for achieving 20%+ reduction)
Year 2 – 10-14.99% reduction in A&E attendances of the selected cohort of frequent attenders in 2017/18 who would benefit from mental health and psychosocial interventions.	20%
Year 2 – 5-9.99% reduction in A&E attendances of the selected cohort of frequent attenders in 2017/18 who would benefit from mental health and psychosocial interventions.	10%

Supporting guidance and references for CQUIN indicator 4

Coding and Data Quality:

This CQUIN requires a local audit of the data quality of MH attendances within A&E and subsequent agreement of a data quality improvement plan. In order to have assurance that a high proportion of mental health attendances are captured, a high proportion of overall attendances to the ED must be coded appropriately within the ECDS.

It is recommended that the locally agreed data quality plan between CCGs and providers should include agreed local targets for parameters including the % coverage of the key ECDS fields; “Chief Complaint”, “Diagnosis” and “injury Intent”. Commissioners and providers should be seeking to have implemented ECDS with high levels of data completeness by end of 2018/19. Therefore, as a guide, best practice is recommended as:

- By end Q2: 95% of attendances have a valid chief complaint recorded
- By end Q2: 95% of attendances have a valid diagnosis field (either confirmed or suspected) recorded.
- By end Q2 80% of relevant attendances[20] have ‘injury intent’ recorded; by end Q4 95% of relevant attendances have ‘injury intent’ recorded

[20] For injury data this is defined as the number of patients who have a diagnosis defined as an injury [injury flag = 1 in the diagnosis table] in whom the ‘Injury Intent’ and‘ Injury Mechanism’ data fields are completed.

These thresholds are in view of the fact that most areas have already made good progress in implementing the ECDS. However, given the different levels of implementation readiness, there is local flexibility for commissioners and providers to agree different % coverage thresholds to those recommended above, as well as local agreements for partial payments where good progress is made but the locally agreed thresholds are not met.

A list of recommended SNOMED codes is included below to help to bring national consistency to counting mental health attendances, based on the codes that are currently approved for inclusion in the ECDS in 2018/19. This list of 'mental health' codes may be subject to further improvement, based on learning from implementation of the ECDS:

a) a 'mental health' chief complaint indicated in the below table:

Chief Complaint	**SNOMED codes**
Self-harm	248062006
Suicidal thoughts	267073005
Depressive disorder	35489007
Anxiety disorder	48694002
Behaviour : unusual	248020004
Behaviour : agitated / violent	248004009
Hallucinations / delusions	7011001

OR;

b) a 'mental health' diagnosis included in the below table

Mental health diagnosis	**SNOMED codes**
Personality disorder	33449004
Eating disorder	72366004
Anxiety disorder	197480006
Depressive disorder	35489007
Bipolar affective disorder	13746004
Schizophrenia	58214004
Psychotic disorder	69322001
Somatisation disorder	397923000
Somatoform pain disorder	30077003
Dissociative disorder	44376007
Factitious disorder	50705009
Adjustment disorder	17226007
Illicit drug use	308742005
Alcohol dependence	66590003
Dementia	52448006

OR

c) an injury intent of 'self-inflicted injury'[21] included in the below table

Injury Intent	SNOMED CODE
Self-inflicted injury	276853009

In order to capture the full extent of self-harm presentations, *'injury intent' – 'self-inflicted injury'* needs to be recorded, as this will represent a significant proportion of mental health activity in A&E.

Inequalities in accessing mental health
For the new cohort of frequent attenders in year 2 of the CQUIN, there is an expectation that commissioners and providers will identify specific groups who experience inequalities in access mental health (or related) services that meet their needs. Particular inequalities in access are likely to differ depending on the area (for instance in some areas access for older adults may be the most pressing issue, and in others access for people from black, Asian and minority ethnic backgrounds might be a greater local concern.

Appropriate access to care and support should be consistent for all, to ensure the best outcomes regardless of any protected characteristics or any coexisting conditions such as learning disabilities or dementia.

The following groups have been identified as experiencing particular inequalities (at a national level) in accessing mental health services:

- People from **black, Asian and minority ethnic** backgrounds.
- People with a diagnosis of borderline or emotionally unstable **personality disorder.**
- **Older adults**: increased attention on dementia may affect healthcare professionals' consideration of other causes of poor mental health in older people.
- **Children and young people**. Many areas do not provide any form of dedicated age-appropriate emergency support.
- **People with co-occurring mental health and drug/alcohol problems** who may be turned away from mental health services if they are intoxicated. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness reports death by suicide as common in people experiencing mental health problems who also have a history of drug or alcohol use. Public Health England has published guidance on this: https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services

Local areas should determine their own cohorts of people to meet needs, based on local demographics and priorities.

Information Sharing:

[21] If the chief complaint is not recorded as 'self-harm', 'self-inflicted injury' is the most suitable SNOMED code to record injury intent as intentional self-harm, e.g. overdose

Following the original publication of the CQUIN, in August 2017 NHS England produced some guidance for local areas to assist with queries regarding information sharing. This guidance is outlined below for additional clarity.

The following guidance has been compiled by NHS England's Adult Mental Health team to support local partners working to implement CQUIN Indicator 4, 'Improving services for people with mental health needs who present to A&E'.

It has been approved by data sharing and privacy experts in NHS England's Information and Transparency Group. Its purpose is to help staff in acute and mental health providers, and commissioners, to understand the positive approach to information sharing and information governance required to enable them to successfully achieve the CQUIN's aims in the context of the relevant legal and policy frameworks.

It is by no means exhaustive and local partnerships need to work together to work through the implications, details and challenges.

Key extract from the CQUIN Indicator Specification document:

'Central to the CQUIN is the recognition that information sharing practices within the NHS itself and beyond need to improve, particularly for patients with mental health needs, in order to improve their experiences of care and outcomes. The issue of missed opportunities to share information in the interest of patient safety has also been raised by coroners on many different occasions following suicides and other serious incidents, with misplaced concerns about patient confidentiality often cited as a contributory factor. The information sharing practices encouraged by the CQUIN support the Caldicott Review's assertion that the duty to share information can be as important as the duty to protect patient confidentiality, and that health and social care professionals should have the confidence to share information in the best interests of their patients.[22] [23] Information sharing agreements where they are not already in place should be expedited.[24,] (pp. 52-3)

Key principles:

- The ultimate aim of the CQUIN is to ensure that people are receiving the most appropriate care for their needs. This includes identifying unmet mental health needs and tailoring interventions accordingly.

- The nature of the CQUIN means that patient-level data is used to improve the direct care of patients. The Health and Social Care (Quality and Safety Act)

[22] Caldicott review: information governance in the health and care system: https://www.gov.uk/government/publications/the-information-governance-review
[23] NHS England, A Quick Guide to Sharing Patient Information for Urgent & Emergency Care: http://www.nhs.uk/NHSEngland/keogh-review/Documents/160203-qucik-guide-Sharing-Patient-Information-for-Urgent-Care.pdf
[24] The Information Governance Alliance (hosted by NHS Digital) and the Centre of Excellence for Information Sharing have produced helpful resources: http://systems.digital.nhs.uk/infogov/iga/resources/infosharing & http://informationsharing.org.uk/our-work/learning-good-practice/ & http://informationsharing.org.uk/our-work/resources/

2015 actively puts a duty on organisations to share information for direct care. Sharing for direct care can take place across departmental and organisational boundaries.

- Rule 2 of the Health & Social Care Information Centre (now NHS Digital) publication, *A guide to confidentiality in health and social care* (September 2013) states that 'Members of a care team should share confidential information when it is needed for the safe and effective care of an individual'. Information should therefore be shared on a need-to-know basis and always in the best interests of the patients. For the purposes of this CQUIN, 'care teams' are effectively multi-disciplinary virtual teams working with patients across traditional departmental and organisational boundaries.

- The key Caldicott principle to note for this CQUIN is principle 7 from the 2013 Caldicott 2 guidance, *Information: To share or not to share? The Information Governance Review* (March 2013): that the duty to share information can be as important as the duty to protect patient confidentiality.

- Chapter 3 from the guidance (which applies across both health and social care) provides further specific helpful advice, for example:

    - 'The Review Panel found a strong consensus of support among professionals and the public that safe and appropriate sharing in the interests of the individual's direct care should be the rule, and not the exception.' (p. 37)
    - 'For the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual.' (p. 38)
    - 'The Review Panel concludes that organisations should pay closer attention to the appropriate transfer of information when people cross organisational boundaries.' (p. 46)
    - 'The Review Panel concludes that a registered and regulated professional's primary concern must be for the health and wellbeing of the individual to whom they are providing direct care and…the presumption should be in favour of sharing for an individual's direct care.' (p. 47)
    - 'The Review Panel concludes that for direct care, when a professional is satisfied the recipient has a legitimate relationship with the patient, and that the recipient understands any particular issues or conditions that apply, the information can be shared with the individual's implied consent. The recipient then becomes responsible and accountable for that information in a professional capacity.' (p. 47)
    - 'The Review Panel also concludes that organisations employing health and social care professionals must support the safe and effective sharing of personal confidential data for direct care between professionals and staff with a legitimate relationship to an individual.' (p. 47)

Sharing data and information between teams operating in acute hospital Emergency Departments

- To maximise the benefit of this scheme to patients, selecting the cohort of patients identified as having the highest number of A&E attendances and who could benefit from a specialist mental health assessment and subsequent interventions does not need to be limited to patients who have previously been referred to the acute hospital liaison mental health (aka liaison psychiatry) team.

- A liaison mental health department functions as an integrated department in an acute hospital alongside other specialties. Liaison mental teams provide care for the same patients as the rest of acute hospital staff and at an organisational level this should be reflected in joint operational policies and service level agreements.

- Given that the department of liaison mental health directly delivers clinical care in the Emergency Department, they are not a third party but part of the acute hospital operating on-site, and a positive approach to internal information sharing should therefore be adopted, especially in the context of this CQUIN, the primary aim of which is to improve care for certain patients.

- It should be borne in mind that for the phase of the CQUIN which requires collaborative care planning, provider staff will need to obtain explicit consent from patients, as patients need to be involved in the co-production of plans. Where onward referral is necessary from an acute hospital department such as the liaison mental health team to an out-of-hospital service such as a community mental health team, the process for obtaining patient consent is necessary in the usual way. The wishes of those patients who do not consent to be involved should be respected and they should not be included as part of the cohort. As a result it is important that provider staff carefully and sensitively explain the purpose of this scheme to patients, emphasising the express purpose and opportunities to improve their care.

Sharing data and information between acute and mental health providers, and other NHS organisations

- Linking or cross-referencing different datasets (e.g. A&E HES and MHSDS) to understand which patients who attend frequently are known to both acute and mental health services, and then selecting those who the data suggests could benefit from tailored interventions, is an equally legitimate and potentially complementary approach if sound information governance principles are followed[25]. Where patients are already under the care of mental health services and more than one organisation is already involved in the patient's care (e.g. an acute trust following the patient's attendance at A&E), then there

[25] NHS England has obtained approval from the Confidentiality Advisory Group to allow personal data to be used for Risk Stratification, for both case-finding and commissioning. Each requires a slightly different approach.

is a positive duty for mental health provider staff and acute provider staff to share relevant clinical information as set out in the GMC's Good Medical Practice guidance – in these circumstances consent is implied and the patient should be informed. This is further clarified in the GMC's guidance on delegation and referral. Where onward referral is proposed to an organisation which is not already involved in the patient's care, explicit consent must be sought from the patient.

- Secondary uses of existing patient-identifiable data are unlikely to be possible without the explicit consent of the patient. Where it is deemed impracticable for this to be sought, the data can still be used in a pseudonymised form. This is data that does not directly identify an individual, but usually has one strong identifier such as the NHS number so that those people with access to IT systems can re-identify the patient. This process of re-identification must be done by someone with a legitimate relationship to the patient. Consent will be required for any data required to be linked to primary care – unless the patient is currently open to an acute hospital liaison mental health service, access to their GP medical records will require the patient's written authorisation. In cases where there is doubt, professionals from other different NHS organisations (e.g. primary care, ambulance, NHS 111) should seek advice from their Caldicott Guardian. It is equally important to recognise that information sharing between professionals and patients is necessary to enable shared decision making.

Sharing data and information between the NHS and non-NHS organisations (e.g. the police, local authorities, voluntary sector organisations)

- Areas should already be able to draw on existing local work undertaken to date on information sharing agreements by local Mental Health Crisis Care Concordat partnerships, which have been in place since 2015. Most multi-agency sharing is done on a consent basis. Other services and organisations involved in local CQUIN schemes as named above will be expected to consult with their own Caldicott Guardians.

- Care plans, once co-produced with the patient and if the patient is content, should be copied/circulated to all involved professionals. Care plans can be attached to the patient's Electronic Patient Record where possible.

- The Information Commissioner's Office (ICO) has produced guidance on Privacy Impact Assessments (PIAs), which helps partners to find collectively-agreed solutions to both issues of gaining patient consent and other local concerns held by partners. See https://ico.org.uk/media/for-organisations/documents/1595/pia-code-of-practice.pdf.

- The PIA is tool for identifying risks to privacy, which can therefore help to highlight what actions may need to be taken to mitigate those risks and by whom. It is also an opportunity for partners to develop relationships, work collaboratively to understand the cultural benefits to partners and build their understanding, confidence and trust in each other which ultimately underpins any successful information sharing practices.

- The Centre of Excellence for Information Sharing have produced materials which partners can use to work some of the issues around information sharing for people with mental health problems, particularly those experiencing a mental health crisis: http://informationsharing.org.uk/policy-areas/health/. Along with providing a raft of materials, including draft information sharing agreements (which should be informed by PIAs); the Centre have also published a thematic report that highlights the key cultural factors that impact on information sharing across all policy areas: http://informationsharing.org.uk/news/cc-themes/.

- The NHS RightCare team have produced a resource pack on 'Setting up a High Intensity User service', including a sample information sharing consent form, which may be useful.

- The Information Governance Alliance (IGA) and Healthcare Quality Improvement Partnership (HQIP) have recently published a guide describing how IG laws and principles apply to the use of personal data in local or regional multi-agency healthcare quality improvement studies. This may also be useful.

5. Transitions out of Children and Young People's Mental Health Services (CYPMHS)

Indicator 5	
Indicator name	Transitions out of Children and Young People's Mental Health Services (CYPMHS)
Indicator weighting (% of CQUIN scheme available)	0.25%
Description of Indicator	This CQUIN aims to incentivise improvements to the experience and outcomes for young people when they transition out of Children and Young People's Mental Health Services (CYPMHS) on the basis of their age. This CQUIN is constructed so as to encourage greater collaboration between providers spanning the care pathway. There are three components of this CQUIN: 1. a case note audit in order to assess the extent of Joint-Agency Transition Planning; and 2. a survey of young people's transition readiness ahead of the point of transition (Pre-Transition / Discharge Readiness); and 3. a survey of whether young people are meeting their transition goals after transition (Post-Transition Goals Achievement Survey). This CQUIN does not prescribe the wording for surveys, nor does it require a particular method for taking this information – such as online or telephone surveying. This is to be agreed at a local level and as appropriate for the young person, and signed off by the sending or receiving service, commissioners, and young people. CCGs must be satisfied that the questionnaire wording and methods provide adequate answers to the two questions: • Of all young people transitioning out of CYPMHS, how many reported feeling prepared for transition? • Of all young people transitioning out of CYPMHS and into a relevant CCG-commissioned service, how many reported that they were meeting their transition goals? **<u>Key Definitions & Scope</u>** *Transition*

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	‘Transition’ and ‘transitioning’ in this CQUIN, means the transfer of young people out of CYPMHS to other services (adult mental health services and other relevant CCG-commissioned services), or being discharged, **as a consequence of reaching a certain age**. The age of transition varies locally, with young people in most areas transitioning at 18 years, but others at 16 or 25, or at a needs-based or condition-specific time. *Which young people does this CQUIN apply to?* This CQUIN applies to any young person transitioning or discharging out of CYPMHS as a consequence of their age, whatever that age may be, as may be dictated by local commissioning arrangements. It therefore applies just as readily for a 16-year-old as for a 25-year-old leaving CYPMHS. It applies for the following transfers of care: • Young people transitioning out of CYPMHS into Adult Mental Health Services (AMHS) on the basis of their age; • Young people transitioning out of CYPMHS into other relevant CCG-commissioned services; and • Young people who are discharged from CYPMHS on the basis of their age. It is important to ensure that this group of young people are properly prepared for discharge as they may not have the same level of support that those using relevant CCG-commissioned services following discharge receive. The discharge plan should be co-produced with the young person and relevant agencies wherever possible. The young person, primary care and where relevant other agencies such as social services should be sent the discharge plan. *Sending and receiving services* This CQUIN refers to ‘sending’ and ‘receiving’ services during the transition out of CYPMHS: • The ‘sending’ service is the CCG-commissioned children and young people’s mental health service whose care the young person is receiving up to the point of transition; • The ‘receiving’ service(s) refers to any relevant CCG-commissioned service(s) the young person is moving into from CYPMHS. Relevancy is determined according to which services would

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	need to understand the young person's mental health needs. This might be adult mental health services (AMHS), or other relevant services such as a CCG-commissioned service for young adults with a learning disability – which would need to understand the young person's mental health needs.[26] *Which providers are in scope?* This CQUIN applies to: • All CCG commissioned providers of CYPMHS that extend to the age of transition; • All appropriate CCG commissioned providers of AMHS[27]; and • Providers of other relevant CCG-commissioned receiving services.[28] *Joint Working* The CQUIN has been designed so as to encourage collaboration between providers across the care pathway before, during and after transition. As such, whilst it takes account of different responsibilities for sending and receiving providers, the impact of performance by either provider will be shared (see table of thresholds below). Through this mechanism, the CQUIN is designed to incentivise all parties to contribute to and plan for better transitions for young people. In addition, whilst a number of key actors including primary care and non-CCG commissioned providers cannot be held to account through this CQUIN it we would encourage providers subject to this CQUIN to engage those parties wherever possible, as ultimately their involvement will be important to successful transitions.
Numerator	1.1 The total number of young people who have

[26] There may be multiple receiving services, in which case services will need to coordinate transition management so that the young person is not overburdened with extra transition processes on entering new care settings. It is recommended that CCGs take a pragmatic approach in awarding this CQUIN to receiving services in this instance, for example rewarding services for a single, coordinated survey of young people after transition – rather than requiring each receiving service to conduct one independently. Some young people may be referred for further treatment to adult IAPT services but would not anticipate a transfer during a course of treatment such as CBT which should be a time limited discrete episode of care. If a young person has begun a course of CBT with one service we would expect that course of treatment to be completed prior to discharge

[27] This CQUIN also applies to those providers delivering both CYPMHS and AMHS.

[28] A relevant service is one that either impacts or is impacted by the young person's mental health needs. For example, a young person with complex needs may move into a number of services on transition out of CYPMHS. Some of these may not be AMHS, but would still be relevant to the young person's care pathway and should therefore be in scope for this CQUIN and incentivised as a receiving provider to be part of transition preparations and evaluation.

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	transitioned out of the sending service in question during the reporting period whose case notes evidence Joint-Agency Transition Planning, defined as: Those service users approaching transition who have had a meeting to prepare for transition, at least six months before transitioning, or for individuals who are less than six months from transition age on joining the sending service and at least one month before transition. The meeting should include: • The young person; • The appropriate key worker from the sending service; • Where applicable, a dedicated point of contact for transition from the receiving service; and • Where appropriate and the young person agrees, the young person's parent(s)/carer(s). Where a face to face meeting is not practicable, for example when a young person is moving out of area, this indicator score may be fulfilled by evidence that there has been contact between all the above parties, for example, via a video conference; AND Those service users with complete transition plans at least 6 months prior to transitioning, signed off by: • The sending service; • Where applicable, the receiving service; • The young person; • Where appropriate, and where consent is given, the young person's parent(s)/carer(s). The transition plan must include personal transition goals, jointly agreed with the young person. Where they are transitioning into a receiving service, these goals will be picked up later in a post-transition questionnaire on transition experience. For those entering CYPMHS less than 6 months before their date of transition, these requirements must be fulfilled on entry into CYPMHS and no later than one month before transition; AND

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	Those service users with a named and contactable transition key worker, at least 6 months prior to transition, in the sending service or, where transitioning into AMHS or other relevant CCG-commissioned services, at the receiving service. This key worker must be known to the young person and their contact details shared with the young person. For those entering CYPMHS less than 6 months before their date of transition, these requirements must be fulfilled on entry into CYPMHS and no later than one month before transition; OR 1.2 Of those young people leaving CYP MH services who will not transition to a CCG commissioned service but are discharged and remain in primary care, the number who have a discharge plan that has been developed and shared with the young person and with other relevant agencies such as primary care and social services. The discharge plan must be shared with relevant agencies ahead of discharge. 2. Of the total number of young people who have transitioned or discharged out of the sending service, the number of young people who reported feeling prepared for transition at the point of transition or discharge from CYPMHS within the reporting period as captured by a Pre-Transition / Discharge Readiness survey. 3. Of those young people who have transitioned from CYPMHS to a receiving provider within the reporting period, the number who indicate that they are meeting their personal transition goals as agreed in their transition plan as captured by a Post-Transition Goals Achievement survey.
Denominator	1.1 The number of young people who have transitioned out of the sending service in question during the reporting period who are transitioning into a relevant CCG-commissioned receiving service. 1.2 The number of young people who have transitioned out of the sending service in question during the

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	reporting period who will not transition into a relevant CCG-commissioned receiving service but will instead be discharged and remain in primary care and, in some cases, the care of non-CCG-commissioned services such as social services. The data required for the case note audit is easily available to the sending providers who already have access to case notes and are best placed to assess the numbers of young people transitioning out of CYPMHS during the reporting period. Case notes are updated regularly as standard practice, so it is expected this data will provide information needed swiftly and at the required frequency to track transition planning. The audit is to be conducted retrospectively. 2. The number of young people who have transitioned or discharged out of the sending service in question during the reporting period. [Sending providers must ascertain (through a survey, questionnaire, meeting or other appropriate medium) whether the young person feels prepared for transition at the point of discharge from CYPMHS]. 3. The number of young people who have transitioned to AMHS or other CCG commissioned services from CYPMHS within the reporting period. [Receiving services must ascertain (again, through a survey, questionnaire, meeting or other appropriate medium) whether the young person is meeting their personal transition goals agreed in their transition plan. Where there are multiple receiving services, they must coordinate a single survey, meeting or questionnaire in order to avoid burdening the young person with multiple questions. This should take place at some point during the three months following transition, so that by the end of a quarter commissioners are able to review how many young people who transitioned in the previous quarter reported meeting their transition goals].
Rationale for inclusion	This CQUIN is intended to improve the outcomes for young people who transition out of CYPMHS; to improve young people's experience of transition; to

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	improve young people, parent and carer involvement; and to incentivise the safe transfer of care for young people. The point of transition from CYPMHS is recognised as a point of potential upheaval for young people who may find it difficult to navigate new service settings, or to manage their mental health following discharge from CYPMHS, especially as the availability and offer of support can change dramatically from CYPMHS to AMHS, or other relevant adult services. It is estimated that more than 25,000 young people transition each year[29]. It is reported that this process is often handled poorly, which can result in repeat assessments and emergency admissions for this large cohort of service users at a critical stage in life.[30] There are many reasons for the discontinuities between CYPMHS and AMHS. Research has highlighted how few people make the transition across to adult services, which have a different culture to CYPMHS services and focus more on clear diagnostic categories (Singh, 2009; Singh et al, 2010). The result is that young people are often left with few options at the point of transition, and may go on to develop more severe problems in the absence of an appropriate service. Moreover, even when adult services do accept a referral, there is no guarantee that the young person's transfer will be handled properly, and they may go on to disengage with services altogether. The TRACK study (Singh, 2008) shows that transitions for young people at the age of 18 are poorly managed resulting in only 4% of young people receiving an 'ideal transition'. Transitions for vulnerable groups, such as those within the criminal justice system, can be particularly problematic. Audit data from Birmingham suggests 25-50% of under 25s disengage from mental health services (Birchwood, Conference presentation, 2010). Disengagement from services can be a major problem, leading young adults to re-present in crisis or with greater severity of need later in life, with socially isolated young adults at

[29] CYP IAPT data shows that over three quarters in 2015, 6,387 children or young people were seen with first appointments, 692 of which were aged 17 – or 10.8%. Rounding up to 11% as an estimated proportion of those receiving CYPMHS, which research suggests is 230,000 in total, gives us 25,300 young people aged 17 in CYPMHS each year. Some young people transition earlier and some later, so this does not represent a holistic view of those transitioning. The audit supporting this CQUIN will improve the evidence base in this regard.

[30] The TRACK study (Singh, 2008) shows that transitions for young people at the age of 18 are poorly managed resulting in only 4% of young people receiving an 'ideal transition'.

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	greatest risk of poor health and offending. There are significant risks for young people disengaging or being lost in the transition process. This is a vulnerable point in their development as they leave secondary education, move towards more independent living, gain legal responsibility for their choices and lose those parts of their support network that are only available within CYPMHS.[31] The report of the Children and Young People's Mental Health and Wellbeing Taskforce, *Future in Mind*, recommended joint working and shared practice between services to promote continuity of care during transition. This requires careful planning on the part of both CYPMHS and the receiving service. It also depends upon consistent involvement of the young person. 69% of CYP MH Local Transformation Plans published in 2016 highlighted transition as a key area for development.[32] The transition out of CYPMHS must be supported by a robust and coordinated multi-agency approach to transition planning, with the full involvement of both the sending and the receiving service. This process is further strengthened by early and effective planning, which may start as young as 15 or as late as 25, and putting the young person at the centre of the process to help them prepare. The process, in many ways a preparation for adulthood, will need to support young people to be as independent as possible and to focus on recovery. In addition, *Future in Mind* recommended that vulnerable young people, such as care leavers and young people in contact with the justice system, should be taken into account in local strategic planning on transition. In spite of this, services remain often poorly coordinated, and it is vulnerable services users and their families who are impacted most extremely. This CQUIN seeks to incentivise more robust transition planning and better experiences of transition, and aligns with NHS England's Business Plan 2016-17 principles on:

[31] Singh SP, Paul M, Ford T, Kramer T, Weaver T (2008); McLaren S, Belling R, Paul M, Ford T, Kramer T, Weaver T, Hovish K, Islam Z, White S, Singh SP (2013).
[32] North East Central London Commissioning Support Unit analysis of CYP MH Local Transformation Plans 2016

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	• Upgrading the quality of care and access to mental health and dementia services. • Strengthening primary care services- to break down boundaries to enable the NHS to work better with local communities. • Transforming Commissioning – integrating health and care. • If transition is handled poorly, this is a cohort that is at risk of isolation and escalating needs, and likely to require repeat admissions and reassessments if receiving services are not fully engaged in the transition process. • This represents a significant cost to receiving services, and wider societal costs for those left isolated at a critical point in their lives who may find it more difficult, for example, to find employment without the stability of a smooth transition as they enter adulthood. This CQUIN follows from published NICE guidelines on CYPMH transition, which recommend: • Ensuring transition support. • Ensuring health and social care service managers in children and young people's and adults' services should work together in an integrated way to ensure a smooth and gradual transition for young people. • Involving young people and their carers in service design. • Ensuring that service managers in both adults' and children and young people's services, across health, social care and education proactively identify and plan for young people in their locality with transition support needs. This CQUIN will incentivise providers to collaborate in order to improve transition planning between sending and receiving services, drawing together disparate elements of the care pathway, and to involve young people and (where appropriate) their families/carers in the process in order to improve young people's transition. This will not only provide continuity of support for young people during this important time; it will also encourage cross-agency working and improve communication across service boundaries so that expectations are appropriate and shared, and so that receiving services, will be better prepared to accommodate the young person transferring to them.

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	Cost and cost effectiveness: • A failure to help young people engage with adult services may lead to increased health, welfare and service costs later on. The immediate impact is often in elevated non-attendance rates and premature discharge. According to clinicians consulted during the preparation of this CQUIN, re-engagement involves both repeat assessment and additional appointments to re-establish engagement– both of which are costly. • This CQUIN indicator is based on a local CQUIN that has been implemented successfully in Liverpool and Sefton, where feedback has been positive and the CQUIN is perceived to be cost effective. • The CQUIN does not require a new or extra service to be put in place. It requires managed care pathways and proper discharge or transition planning. • Possible savings: if transition consisted of one transition/discharge planning session with the young person and a key worker from CYPMHS, one 'handover' meeting with both CYPMHS and the receiving service present, and one session to follow up on transition outcomes with the young person, the process would take 4 sessions of clinical time in total. Discharge/transition planning should already be in place in CYPMH services as a matter of course so only 3 sessions should be required. If we anticipate these clinicians are in mid-Band 7 and cost the service £52,000 per annum, and these four sessions total 1.5 days, less than 1% of a clinician's time, the cost would be around £415 per transition. • Costs avoided: in comparison, one episode of crisis liaison is approximated at £222 per contact and one occupied bed day for those in more severe need is calculated at £325. Beyond these two examples, it is anticipated that a well-planned transition will have a far wider impact on future costs by supporting the young person into adulthood and employment and avoiding escalating needs in the absence of liaison with services.
Data source	1. Joint-Agency Transition Planning to be assessed via a case note Audit.

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	The data required for this audit is easily available to the sending providers who already have access to case notes and are best placed to assess the numbers of young people transitioning out of CYPMHS during the reporting period. Case notes are updated regularly as standard practice, so it is expected this data will provide information needed swiftly and at the required frequency to track transition planning. The audit is to be conducted retrospectively. 2. Pre-Transition / Discharge Readiness to be assessed via User Survey / Questionnaire. This CQUIN does not prescribe the wording for surveys, nor does it require a particular method for taking this information – such as online or telephone surveying. This is to be agreed at a local level and as appropriate for the young person, and signed off by the sending service, commissioners, and young people. CCGs must be satisfied that the questionnaire wording and methods provide adequate evidence of young people's preparedness for transition. The results of the survey need to demonstrate how many young people, of all those transitioning out of CYPMHS, answered 'yes' to the following question at the point of exiting CYPMHS: - *Do you feel prepared for transition/discharge?* 3. Post-Transition Experience to be assessed via User Survey / Questionnaire. This CQUIN does not prescribe the wording for surveys, nor does it require a particular method for taking this information – such as online or telephone surveying. This is to be agreed at a local level and as appropriate for the young person, and signed off by the receiving service, commissioners, and young people. CCGs must be satisfied that the questionnaire wording and methods provide adequate evidence of whether young people are meeting their transition goals (as set out in their transition plan). The results of the survey need to demonstrate to commissioners how many young people, of all those transitioning out of CYPMHS into

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	a receiving service, answered 'yes' to the following question at some point during the three months[33] following their transition from CYPMHS into the receiving service: - *Are you meeting your transition goals (as set out in your transition plan)?*
Frequency of data collection	1. Joint-Agency Transition Planning to be subject to half-yearly case note audit with the results presented to commissioners. 2. Pre-Transition / Discharge Readiness to be surveyed as a routine element of a Young Person's pre-transition pathway with CYPMHS, at the point of leaving CYPMHS. Data to be collated on a half-yearly basis and presented to commissioners. 3. Post-Transition Experience to be surveyed as a routine element of a Young Person's post-transition pathway with AMHS or other relevant services, within three months of leaving CYPMHS. Data to be collated on a half-yearly basis and presented to commissioners. Providers will submit results for all elements via the CQUIN Consolidated data collection to NHS England on a half-yearly basis.
Organisation responsible for data collection	1. Joint-Agency Transition Planning data to be collected by sending CYPMHS providers. The data required for this audit is easily available to the sending providers who already have access to case notes and are best placed to assess the numbers of young people transitioning out of CYPMHS during the reporting period. Case notes are updated regularly as standard practice, so it is expected this data will provide information needed swiftly and at the required frequency to track transition planning. 2. Pre-Transition / Discharge Readiness survey data to be collected by sending CYPMHS providers. 3. Post-Transition Experience survey data to be collected by receiving providers.

[33] There is no one time point at which receiving providers must conduct this survey, as transition goals may be on different timescales for different young people – but it must be completed by the time three months have elapsed since transition.

Indicator 5	
Frequency of reporting to commissioner	See table below.
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	See below milestones
Final indicator value (payment threshold)	1. Joint-Agency Transition Planning : 80% 2. Pre-Transition / Discharge Readiness: 80% 3. Post-Transition Experience Survey: 70%
Final indicator reporting date	See milestones below
Are there rules for any agreed in-year milestones that result in payment?	Yes (see below)
Are there any rules for partial achievement of the indicator?	Yes see below.

Milestones for indicator 5

Date/period Milestone relates to	Rules for achievement of Milestone (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1 2017/18	Sending and Receiving Providers to jointly develop engagement plan across all local providers. Sending and Receiving Providers to map the current state of transition planning/level of need and to submit joint report on findings to commissioners. Sending and Receiving Providers to	31st July 2017	10% 15% 15%

Date/period Milestone relates to	Rules for achievement of Milestone (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	develop implementation plan to address identified needs and agree with approach with commissioners.		
Quarter 2 2017/18	Sending and Receiving Providers to update and assure commissioners as to implementation of joint plan to support better transition planning.	31st October 2017	10%
Quarter 3 2017/18	No Milestones		
Quarter 4 2017/18	Sending Provider to undertake Case note Audit assessing those who transitioned out of CYPMHS in Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Sending Provider to undertake assessment of discharge questionnaires for those who transitioned out of CYPMHS in Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Receiving Provider to undertake assessment of post-transition questionnaires of those who transitioned to AMHS or other relevant services from CYPMHS in Q3. Performance rewarded as per rules for partial achievement of the indicator; reward to be applied to all providers subject to this CQUIN. Sending & Receiving Providers to present to commissioners a joint report outlining overall CQUIN progress to date. Results to be submitted to NHS England via	30th April 2018	Up to 25% Up to 10% Up to 10% 5%

Date/period Milestone relates to	Rules for achievement of Milestone (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	CQUIN Consolidated data Collection.		
Quarter 1 2018/19	Sending and Receiving Providers to refresh implementation plan in light of Year1 results and confirm arrangements with commissioners.	30th July 2019	5%
Quarter 2 2018/19	Sending Provider to undertake case note Audit assessing those who transitioned out of CYPMHS from Q1-Q2. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Sending Provider to undertake assessment of discharge questionnaires for those who transitioned out of CYPMHS in Q1-Q2. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Receiving Provider to undertake assessment of post-transition questionnaires of those who transitioned to AMHS or other relevant services from CYPMHS through Q4 2017/18-Q1 2018/19. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Sending & Receiving Providers to present results to commissioners.	31st October 2019	Up to 15% Up to 15% Up to 15%
Quarter 3 2018/19	No Milestones		
Quarter 4 2018/19	Sending Provider to undertake case note Audit assessing those who transitioned out of CYPMHS from Q3-Q4. Performance rewarded as	30th April 2019	Up to 15%

Date/period Milestone relates to	Rules for achievement of Milestone (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN.		
	Sending Provider to undertake assessment of discharge questionnaires for those who transitioned out of CYPMHS in Q2-Q3. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN.		Up to 15%
	Receiving Provider to undertake assessment of post-transition questionnaires of those who transitioned to AMHS from CYPMHS through Q3-Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN.		Up to 15%
	Sending & Receiving Providers to present to commissioners a joint report outlining overall CQUIN progress to date. Results to be submitted to NHS England via CQUIN Consolidated data collection		5%

Rules for partial achievement of indicator 5

For Year 1 (2017/18):

1. Joint-Agency Transition Planning:

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
80% and above	25.0%
70-79.9%	20.0%
60-69.9%	15.0%
50-59.9%	10.0%
49.9% or less	5.0%

2. Pre-Transition / Discharge Readiness Survey:

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
80% and above	10.0%
60-79.9%	8.5%
40-59.9%	7.5%
20-39.9%	5.0%
19.9% or less	0.0%

Post-Transition Experience Survey:

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
70% and above	10.0%
50-69.9%	8.5%
30-49.9%	7.5%
10-29.9%	5.0%
9.9% or less	0%

These payment thresholds are slightly lower than above, in recognition that there may be instances where a young person does not meet their transition goals for reasons beyond the control of the receiving provider. The intention is for this threshold to allow for these instances but simultaneously incentivise receiving providers to do everything in their power to help the young person achieve their transition goals, and to ensure these goals are realistic when set during transition planning.

For Year 2 (2018/19)

1. Joint-Agency Transition Planning:

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
80% and above	15.0%
70-79.9%	12.5%
60-69.9%	10.0%
50-59.9%	5.0%
49.9% or less	0.0%

2. Pre-Transition / Discharge Readiness Survey:

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
80% and above	15.0%
60-79.9%	12.5%
40-59.9%	10.0%
20-39.9%	5.0%
19.9% or less	0.0%

3. Post-Transition Experience Survey

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
70% and above	15.0%
50-69.9%	12.5%
30-49.9%	10%
10-29.9%	5.0%
9.9% or less	0%

6. Offering advice and guidance

Indicator 6	
Indicator name	Offering advice and Guidance (A&G)
Indicator weighting (% of CQUIN scheme available)	0.25%
Description of Indicator	The scheme requires providers to set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative. A&G in the context of this CQUIN refers to structured, non-urgent, electronic A&G provided via telephone, email, or an online system. CCGs may agree with trusts how the local programme of A&G will operate, and the definition of an A&G response may include: • Virtual review of test results (e.g. ECG, bloods) and advice on next steps required. • Supply of a suggested treatment or management plan to the GP (which may include carrying out further investigations in primary care). • Direct booking of diagnostic test (e.g. endoscopy). • Direct booking of intervention, where indicated. • Advice on the appropriate clinic referral (reducing redirected appointments). Clinical responsibility will remain with the GP accessing the A&G service, unless or until the patient is seen face to face in secondary care. In areas where A&G services have been trialled to date, clinical haematology, diabetes and endocrinology, cardiology, gastroenterology and nephrology have been found to offer opportunity. Based on treatment function code, these specialties accounted for 12.4% of GP referrals June 2015 – July 2016 (SUS, 1st OP attendances where source is GMP, GDP and GPwSI, based on General and Acute). In the same data, the following specialties accounted for 36.9% of all GP referrals: • Gynaecology (8%) • Trauma and orthopaedics (7.7%) • ENT (7.4%) • Dermatology (7.3%) • Ophthalmology (6.4%) A guide will be produced in support of the scheme which sets out the practical steps involved in setting up an A&G service.

Indicator 6	
Numerator	A&G coverage: Number of GP referrals seen in elective outpatient specialties which provide A&G.
Denominator	Total number of GP referrals seen in elective outpatient services.
Rationale for inclusion	The GP Forward View set out the need to improve GP access to consultant advice on potential referrals into secondary care. This indicator draws on a number of case studies from around the country where A&G has already begun to be implemented. In 2016 Winpenny et al[34] reviewed 183 studies published in the last 10 years on interventions in primary care aimed at improving the effectiveness and efficiency of outpatient services, including 8 studies on email or phone requests for specialist advice. They concluded that, *"there is substantial opportunity to reduce the number of patients who are seen in outpatient clinics"*. In a Spanish study evaluating virtual consultation services for endocrinology over the 3 year period 2008 – 2010 88% of virtual consultations (where the specialist reviewed the patient's clinical history without the patient attending) were resolved without requiring a hospital visit alongside a reduction in inappropriate referrals from 25% to 10% after introduction of the virtual consultation system.[35] An email GP advisory service staffed by Endocrine / Diabetes Specialist Registrars as part of their training commitment found that a formal referral was only suggested in response to 10% of enquiries (although did not draw conclusions about whether the email service ultimately reduced referrals to outpatient clinic[36]). The design of this CQUIN draws on learning from local areas around the country where A&G services have already been set up. The early outcomes do not yet constitute a robust evidence base on referrals and activity avoided, so have not been generalised into expectations for the wider system, but they do show encouraging early signs. Asynchronous A&G via ERS or an alternative IT system: • Leicester and Lincoln: Anecdotal reports that referrals have decreased but there are no figures to demonstrate this yet. In 2015, 432 A&G requests were responded to, and 68 patients were subsequently referred into the same specialty. No analysis has been done yet on A&G requests that did not result in a referral. • Sandwell and West Birmingham report approximately 25% "supported rejections" of endoscopy referrals

[34] 'Improving the effectiveness and efficiency of outpatient services: a scoping review of interventions at the primary–secondary care interface', Winpenny et al. 2016, Journal of Health Services Research and Policy
[35] Oliva, X., Micaló, T., Pérez, S., Jugo, B., Solana, S., Bernades, C., Sanavia, M. and Delgado, C. (2013). Virtual referral system between specialized endocrinological care and primary care. *Endocrinología y Nutrición (English Edition)*, 60(1), pp.4-9.
[36] Walker, J., Rourke, D., Allen, K., Karavitaki, N., Levy, J. and Wass, J. (2009). An e-mail GP advisory service: a more efficient way of dealing with clinical enquiries. *Br J Hosp Med*, 70(9), pp.532-533.

Indicator 6	

	• Calderdale and Huddersfield: in 2015, 26% of A&G queries were advised to refer in to secondary care.
	• Morecambe Bay: Evaluated the usage of bespoke A&G system for the period from 10 May 2013 to 31 January 2014:
	  ○ GPs reported a reduction of 70 patients who would have been directly referred to OP prior to A&G (39% reduction).
	• Wandsworth CCG implemented "Kinesis" web-based software for asynchronous and synchronous advice in 2012:
	  ○ 74% of queries are answered within 48 hours.
	  ○ In 2015/16 Wandsworth GPs sent 3993 requests via Kinesis, 48% of which did not lead to a referral.
	
	Synchronous A&G via a telephony system:
	• Stockport: Use of the Consultant Connect system for immediate advice from consultants over the telephone. Over the period 22/2/15 – 15/4/16:
	  ○ Call connection rate – 76% (and increasing).
	  ○ Average call answering time – 40 seconds.
	  ○ Average call duration – 3 minutes 44 seconds.
	  ○ Percentage of calls avoiding a hospital outpatient appointment 59% (70% if the request for purely diagnostics is included).

Data source	For the purposes of the main indicator denominator, referrals seen data is already captured in Hospital Episode Statistics / Secondary User Service (HES/SUS). For the numerator, providers will need to report on which specialties are covered by A&G services (this is not already collected) and this will be linked to HES/SUS data to quantify performance. Demand on elective specialties covered by A&G should be tracked locally to provide insight on the impact of the service.
Frequency of data collection	Quarterly
Organisation responsible for data collection	The numerator and denominator will be collected at Provider level.
Frequency of reporting to commissioner	The provider will meet with Commissioners at least quarterly, initially to review the implementation of the A&G service and then to monitor impact through the main indicator. Providers of all levels participating in the scheme will have an incentive to earn the reward and improve, as the target is expressed as a proportion of local referral volumes.
Baseline period/date	The target for the main indicator is not relative to a baseline but Q1 2017/18 will provide a picture of A&G coverage prior to CQUIN mobilisation.

Indicator 6	
Baseline value	Proportion of GP referrals made to elective outpatient specialties which provide access to A&G services.
Final indicator period/date (on which payment is based)	Q4 2018/19
Final indicator value (payment threshold)	75% of GP referrals are made to elective outpatient specialties which provide access to A&G services.
Final indicator reporting date	30th April 2019
Are there rules for any agreed in-year milestones that result in payment?	Payment will be made quarterly over the two year scheme, upon evidence of milestones in the following table.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes

Milestones for indicator 6

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1 2017/18	• Agree specialties with highest volume of GP referrals for A&G implementation. • Agree trajectory for A&G services to cover a group of specialties responsible for at least 35% of GP referrals by Q4 2017/18. • Agree timetable and implementation plan for introduction of A&G to these specialties during the remainder of 2017/18. • Agree local quality standard for provision of A&G, including that 80% of asynchronous responses are provided within 2 working days.	30 July 2017	25% of year 1 reward

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 2 2017/18	• A&G services mobilised for first agreed tranche of specialties in line with implementation plan and trajectory. • Local quality standard for provision of A&G finalised. • Baseline data for main indicator provided.	31 October 2017	25% of year 1 reward
Quarter 3 2017/18	• A&G services operational for first agreed tranche of specialties. • Quality standards for provision of A&G met. • Data for main indicators provided. • Timetable, implementation plan and trajectory agreed for rollout of A&G services to cover a group of specialties responsible for at least 75% of GP referrals by Q4 2018/19.	31 January 2018	25% of year 1 reward
Quarter 4 2017/18	• A&G services operational for specialties covering at least 35% of total GP referrals by start of Q4 2017/18 and sustained across the quarter. • Quality standards for provision of A&G met. • Data for main indicator provided.	31 May 2018	25% of year 1 reward
Quarter 1 2018/19	• A&G services introduced in line with Q1 trajectory and implementation plan. • Quality standards for provision of A&G met. • Data for main indicator provided.	31 July 2018	15% of year 2 reward

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 2 2018/19	• A&G services introduced in line with Q2 trajectory and implementation plan. • Quality standards for provision of A&G met. • Data for main indicator provided.	31 October 2018	15% of year 2 reward
Quarter 3 2018/19	• A&G services introduced in line with Q3 trajectory and implementation plan. • Quality standards for provision of A&G met. • Data for main indicator provided.	31 January 2019	15% of year 2 reward
Quarter 4 2018/19	• A&G services in place for a group of specialties responsible for receiving 75% of total GP referrals by start of Q4 and sustained across the quarter. • Local quality standards met. • Data for main indicator provided.	30 May 2019	55% of year 2 reward

Rules for partial achievement of indicator 6

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
≥35%	**100% of Q4 2017/18 reward**
30% - <35%	80% of Q4 2017/18 reward
25% - <30%	60% of Q4 2017/18 reward
20% - <25%	40% of Q4 2017/18 reward
≥75%	**100% of Q4 2018/19 reward**
65% - <75%	80% of Q4 2018/19 reward
55% - <65%	60% of Q4 2018/19 reward
45% - <55%	40% of Q4 2018/19 reward

7. NHS e-Referrals (Year 1 only)

Indicator 7	
Indicator name	NHS e-Referrals CQUIN
Indicator weighting (% of CQUIN scheme available)	0.25% (for Year 1 only. Acute providers transition to the Risky Behaviours CQUIN for Year 2)
Description of Indicator	This indicator relates to GP referrals to consultant-led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral Service. It is not looking at percentage utilisation of the system. All providers to publish ALL such services and make ALL of their First Outpatient Appointment slots available on NHS e-Referral Service (e-RS) by 31 March 2018 following the trajectory below. Undertake required work on their Directory of Services to publish ALL services on the NHS e-Referral Service. The guidance below sets out the practical steps for delivery in support of this scheme.
Numerator	For Q1: i. Submit a baseline plan to deliver Q2, Q3 and Q4 targets. For Q2 to Q4 providers will be required to evidence that: i. Services are published and available to receive referrals through NHS e-Referral Service as set out in the Milestones below. The numerator will be the count of published first outpatient services listed on the Directory of Services e-RS extract EBSX05; and ii. Adequate slot polling is taking place to allow patients to book appointments evidenced by a reduction in 'Appointment Slot Issues' to a rate of 4% or less. The numerator for this measure will be the number of Appointment Slot Issues received by provider.
Denominator	For Q1 - to assess that all services are published on the NHS e-Referral Service (e-RS), providers will be required to evidence a definitive list of all services/clinics accepting 1st O/P referrals and details of the e-RS services they are mapped to. For Q2 – Q4 point i) The denominator will be the number of first outpatient services, which receive GP referrals, as identified in the Q1 baseline plan. For point ii) it will be the total number of first outpatient bookings received through e-RS.
Rationale for inclusion	This incentive is designed to encourage a move away from any paper based processes in line with the target for Q4 but

Indicator 7	
	recognising that each trust will need to decide how their services are configured and this may include referral only services (further information in the guidance). For bookable services providers should adjust their e-RS slot polling range, in line with their actual waiting time and based on their available capacity and operating model for each service but ensure a transition away from paper based referrals.
Data source	e-RS System and Providers. For Q2-Q4 measures detailed above: i. will use data from the Directory of Services e-RS extract EBSX05; and ii will use the monthly e-RS Appointment Slot Issues report.
Frequency of data collection	Quarterly
Organisation responsible for data collection	Providers
Frequency of reporting to commissioner	Monthly
Baseline period/date	April 2017
Baseline value	Varies by Provider
Final indicator period/date (on which payment is based)	March 2018
Final indicator value (payment threshold)	Enabling all referrals into the Provider Trust through e-RS.
Final indicator reporting date	31 March 2018
Are there rules for any agreed in-year milestones that result in payment?	Quarterly milestones as below.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	As this is a staged CQUIN, payments will be made for attainment of the thresholds set out at each quarter. There will be no payment for partial achievement outside of this staged approach.

Milestones for Indicator 7

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1 01/04/2017 to 30/06/2017	Providers should supply a plan to deliver Q2, Q3 and Q4 targets to include: • a definitive list of all services/clinics accepting 1st O/P referrals and details of the NHS e-RS services they are mapped to, identifying any gaps to be addressed through this CQUIN. • a trajectory to reduce Appointment Slot Issues to a level of 4%, or less, over Q2, Q3 and Q4.	01/07/2017	25%
Quarter 2 01/07/2017 to 30/09/2017	• 80% of Referrals to 1st O/P Services able to be received through e-RS. • Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals - details of slot polling ranges (as recorded on EBSX05) and Appointment Slot Issues by service reducing to 4% or less in line with the agreed trajectory set in Q1.	01/10/2017	25%

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 3 01/10/2017 to 31/12/2017	• 90% of Referrals to 1st O/P Services able to be received through e-RS. • Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals - details of slot polling ranges (as recorded on EBSX05) and Appointment Slot Issues by service reducing to 4% or less in line with the agreed trajectory set in Q1.	02/01/2018	25%
Quarter 4 01/01/2018 to 31/03/2018	• 100% of Referrals to 1st O/P Services able to be received through e-RS. • Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals - details of slot polling ranges (as recorded on EBSX05) and Appointment Slot Issues by service reducing to 4% or less in line with the agreed trajectory set in Q1.	01/04/2018	25%

Rules for partial achievement of indicator 7

Quarter 2

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
Achieving 50% to 60% of referrals to 1st O/P Services able to be received through e-RS.	50% of available Q2 scheme.
Achieving 61% to 70% of referrals to 1st O/P Services able to be received through e-RS.	60% of available Q2 scheme.
Achieving 71% to 79% of referrals to 1st O/P Services able to be received through e-RS.	70% of available Q2 scheme.
Achieving 80% or above of referrals to 1st O/P Services able to be received through e-RS.	100% of available Q2 scheme.

Quarter 3

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
Achieving 61% to 70% of referrals to 1st O/P Services able to be received through e-RS.	50% of available Q3 scheme.
Achieving 71% to 80% of referrals to 1st O/P Services able to be received through e-RS.	60% of available Q3 scheme.
Achieving 81% to 89% of referrals to 1st O/P Services able to be received through e-RS.	70% of available Q3 scheme.
Achieving 90% or above of referrals to 1st O/P Services able to be received through e-RS.	100% of available Q3 scheme.

Quarter 4

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
Achieving 71% to 80% of referrals to 1st O/P Services able to be received through e-RS.	50% of available Q4 scheme.
Achieving 81% to 90% of referrals to 1st O/P Services able to be received through e-RS.	60% of available Q4 scheme.
Achieving 91% to 99% of referrals to 1st O/P Services able to be received through e-RS.	70% of available Q4 scheme.
Achieving 100% of referrals to 1st O/P Services able to be received through e-RS.	100% of available Q4 scheme.

Supporting Guidance for e-referrals CQUIN indicator 7

2017/18 e-Referrals CQUIN Guidance

This CQUIN has been introduced to:

- Support Providers with the transition to receiving all GP referrals through the NHS e-Referral Service, in line with the expectations of the NHS Standard Contract.
- Reduce the number of patients that experience an 'Appointment Slot Issue'.

There are two main elements to the CQUIN; the availability of services and the availability of appointments.

1) All providers to publish ALL of their services and make ALL of their First Outpatient Appointment slots available on e-RS by 31 March 2018.

This element of the CQUIN will require providers to:

- Review all of their outpatient clinics.
- Identify which clinics accept GP referrals for First appointments.
- Cross reference against available NHS e-Referral Services.

Each clinic that accepts GP referrals will need to be mapped to one - or more - NHS e-Referral service. Additionally, the provider will need to ensure that all First Outpatient Appointments within these clinics has been made available to the NHS e-Referral Service (e-RS). Minimising carve out of clinic slots supports better overall Capacity and Demand management.
www.england.nhs.uk/ourwork/demand-and-capacity/

Where clinics are identified without appropriate mappings to e-RS, the provider will need to identify existing services to map to, or plan for the creation of additional e-RS services.

To support this, NHS Digital will introduce the concept of 'referral only' services to the NHS e-Referral Service in early Q1 2017/18. Referral only services will enable providers to access clinical referral information through e-RS without the need for a booked appointment. This change recognises that, for some services, up front patient booking is not the optimal pathway and may have prevented some services being made available to e-RS to this point. The Provider will be expected to book an appointment for the patient within e-RS after receiving the referral information. Further information on referral only services will be made available by NHS Digital in the coming months.

Providers will then need to submit baseline plans to make all of their services available for referral via e-RS to the following schedule:

- Q2 2017/18: 80% of Referrals to 1st O/P Services able to be received through e-RS.
- Q3 2017/18: 90% of Referrals to 1st O/P Services able to be received through e-RS.
- Q4 2017/18: 100% of Referrals to 1st O/P Services able to be received through e-RS.

Suggested approach for compiling baseline plans:

i. Work with IT and/or PAS back office colleagues to identify all consultant-led outpatient clinics that have accepted GP referrals to see patients for their first (new) attendance over the last 12 months.

ii. Confirm which e-RS services are mapped to each of the clinics identified in step 1. It may be possible to pull this information directly from the PAS along with the clinic information. Otherwise, a manual check of clinics will be required.
    a. Where a clinic is mapped to e-RS services, ensure that all first outpatient slots within that clinic have been made available to e-RS, or agree a plan to do so that supports the Q2-Q4 availability trajectory.

iii. Where no clinic mapping to an e-RS service(s) exists, work with clinicians to review the existing Directory of Services to agree whether each clinic can be linked to an existing service, or if a new service needs to be defined and mapped. This may include the use of Referral Only services, if appropriate.

iv. The above three steps will identify all clinics that need to be made available to e-RS along with their actual or future e-RS service mappings.

v. Separately, work with Information Team colleagues to analyse GP Referral volumes by specialty, so that you understand which combination of specialties and services need to be made available to achieve the 80% and 90% thresholds at the end of Q2 and Q3 respectively.

vi. Taken together, all of this information should enable a Provider to submit a baseline plan to deliver the Q2, Q3 and Q4 trajectory.

2) <u>Adequate slot polling is taking place to allow patients to book appointments evidenced by a reduction in 'Appointment Slot Issues' to a rate of 4% or less.</u>

An 'Appointment Slot Issue' (ASI) occurs when a patient is unable to book their appointment through the NHS e-Referral Service, for one of two reasons. The first is that, in very rare circumstances, a technical issue can prevent an appointment slot from being shown or booked. The second and usual reason is that organisations providing directly bookable services have not made sufficient appointment slots available to e-RS.

As well as inconveniencing and often confusing patients, ASIs cause a number of dis-benefits for providers, including typically costing twice as much to process than when a patient is able to book through e-RS.

Providers need to understand the true wait for a First Outpatient Appointment within each service, and slot polling ranges should be set at (or in excess of) this wait to ensure equity of access. Where true waits exceed usual partial booking windows (typically 6 weeks) this may require the provider to book all of the outpatient waiting list to ensure that all patients are seen 'in turn' and to prevent the impression of e-RS referred patients 'queue jumping'.

Making polling ranges match waiting times is a necessary pre-requisite of moving to an environment where all GP referrals are made through e-RS, as well as being the most effective way of reducing ASIs.

NHS Digital has fully revised its guidance for the effective management of Appointment Slot Issues and has published a case study on how Cambridge University Hospitals successfully reduced their level of ASIs. Both documents, along with a presentation on the benefits of matching polling ranges to waiting times, are available from the Document Library at www.digital.nhs.uk/referrals

Where providers have first outpatient waiting times in excess of those required to deliver sustainable RTT performance, a number of effective capacity and demand tools are available from NHS Improvement.
https://improvement.nhs.uk/resources/outpatient-capacity-and-demand-tool/
or via NHS England www.england.nhs.uk/ourwork/demand-and-capacity/

8. Supporting proactive and safe discharge

2017/18

There are three versions of this CQUIN indicator:

- 8a – Applicable to Acute Trusts
- 8b – Applicable to Community Trusts
- 8c – Applicable to Care Homes

2018/19

In light of the specific challenges around delivering provider side balance, NHS England has agreed with NHS Improvement to offer a temporary relaxation of an element of the scheme for acute providers. Our shared position is that this concession is being made in 2018/19 only. On the basis that there are multiple initiatives supporting the discharge agenda, we have agreed to suspend the 'proactive and safe discharge' indicator for acute providers, with the quantum (0.25%) being added to the 'Supporting Local Areas' element of the CQUIN scheme, as a temporary measure for 2018/19.

This change will have implications for the linked indicators in Community and Care Home settings. For Community providers, this indicator no longer exists and we expect CCGs to either take this opportunity to include a local CQUIN indicator in their contracts, or increase the weights of the remaining five indicators in the scheme to 0.3%. For Care Home providers this indicator will continue. It has been revised and below is the updated indicator specification.

Indicator 8a – Acute Trusts (2017/18 only)

Indicator 8a – Acute Trusts	
Indicator name	Supporting Proactive and Safe Discharge – Acute Providers
Indicator weighting (% of CQUIN scheme available)	0.25%
Description of Indicator	**Year 1 17/18** • Part a) 40% of weighting for this measure Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories. • Part b) 20% of the weighting for this measure (applicable to acute only, with category 1 or 2 A&E departments). **Emergency Care Data Set (ECDS)** Type 1 or 2 A&E providers to have demonstrable and credible planning by the end of Quarter 1, in order to

Indicator 8a – Acute Trusts	
	commence timely submission of data from 1st October 2017. See milestone section for detail of the requirements. Further information on the ECDS can be found at: https://www.england.nhs.uk/ourwork/tsd/ec-data-set/ Where Part b is not applicable to a provider this weighting should be applied to Part a. • Part c) 40% of weighting for this measure. Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17). Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate. **Year 2 2018/19** N/A
Numerator	**Year 1** Finished discharge episodes within Q3 and 4 of 2017/18, discharged to usual place of residence within 3- 7 days of admission of patients aged 65+ admitted via non-elective route. **Year 2** N/A
Denominator	**Year 1** Finished discharge episodes of patients aged 65+ admitted via non-elective route within Q3 and 4 with a LOS of >2. **Year 2** N/A
Rationale for inclusion	There is a considerable evidence for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the ability of emergency departments to respond to people's needs, and increasing costs to local health economies. Unnecessary delay in discharging older patients from hospital is a systemic problem with a rising trend -

Indicator 8a – Acute Trusts	
	between 2013 and 2015 recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million bed days[37]. For older people in particular, we know that longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs. Local A&E Delivery Boards are being asked in 2016/17 to implement key initiatives to address some of the major underlying issues causing delayed discharges. This CQUIN builds upon the 2016/17 A&E Plan discharge-specific activity to support systems to streamline discharge pathways, embed and strengthen the discharge to assess* pathway to maximum effect, and to understand capacity within community services to support improved discharge. This is a two year CQUIN that works across local health economies that aims to improve discharges for patients across all wards within hospitals. The desired outcomes will be improvement in patient outcomes, improvement in patient flow, and reduction in delayed discharges (and thus reduction in associated costs). Although this CQUIN includes a measure using acute data, it is an indicator of how well the whole system works to support timely discharge. Distribution of the CQUIN amount on achievement of the target between acute, community and NHS-commissioned care home beds would need to be determined locally. *Definition of discharge to assess38: Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where possible) or another community setting. This is where assessment for longer -term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Commonly used terms for this are: 'discharge to assess', 'home first', 'safely home', 'step down'.
Data source	HES / SUS
Frequency of data collection	Quarterly
Organisation	HES data available via NHS Digital

[37] National Audit Office, (2016) Discharging Older Patients from Hospital
[38] Quick Guide: Discharge to assess www.nhs.uk/quickguide

Indicator 8a – Acute Trusts	
responsible for data collection	
Frequency of reporting to commissioner	Quarterly
Baseline period/date	**Year 1** Q3 and Q4 2016/17
Baseline value	
Final indicator period/date (on which payment is based)	**Year 1** End of 2017/18 **Year 2** N/A
Final indicator value (payment threshold)	**Year 1 (17/18):** • 2.5% point increase discharge to usual place of residence: across Q3 and Q4 2017/18 OR an increase to 47.5% across Q3 and 4 2017/18 **Year 2 (18/19):** N/A
Final indicator reporting date	Discharge to usual place of residence: **Year 1**: End of Q4 2017/18 **Year 2**: N/A
Are there rules for any agreed in-year milestones that result in payment?	Yes. See below.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes. See below.

Milestones for indicator 8a – Acute Trusts

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 2 Year 1 Part a)	i) Map and streamline existing discharge pathways across acute, community and NHS-care home providers and roll-out protocols in partnership across local whole-systems. ii) Develop and agree with the commissioner a plan, baseline and trajectories which reflect expected impact of implementation of local initiatives to deliver the part b indicator for year 1 and year 2. As part of this, agree what proportion of the part b indicator for each year will be delivered by the acute provider and what proportion will be delivered by the community provider. Achievement of part b will require collaboration between acute and community providers.	End of Q2 2017/18	40% of 100% in Year 1
Quarter 1 Year 1 Part b)	i) Type 1 or 2 A&E provider has demonstrable and credible planning in place to make the required preparations (e.g. by upgrading IT systems and training staff) so that the Emergency Care Data Set (ECDS) can be collected and returned from 1st October 2017.	End of Quarter 1	15% of 100% in Year 1
Quarter 3 Year 1 Part b)	ii) Type 1 or 2 A&E provider is returning data at least weekly AND 95% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 95% of patients have a diagnosis. Chief complaint should be any value from the ECDS Chief Complaint code set (SNOMED CT). Diagnosis should be any value from the ECDS diagnosis code set (SNOMED CT).	End of Quarter 3	5% of 100% in Year 1

Rules for partial achievement for indicator 8a – Acute Trusts - Part c)

This payment will be calculated on the combined total of provider and community contributions not on an individual provider performance.

Percentage point increase in discharge to usual place of residence

Year 1(2017/18).

By the end of Q4 2.5% point increase from baseline in no. patients discharged to usual place of residence.

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
Less than 1.5% point increase	No payment
1.5 up to 1.99% point increase	50% payment
2 up to 2.49% point increase	80% payment
2.5% point increase or greater	100% payment

Or

Year 1 (2017/18)

By the end of Q4 47.5% in % of patients discharged to usual place of residence

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
Less than 40%	No payment
40% up to 44.9%	50% payment
45% up to 47.4%	80% payment
47.5% or greater	100% payment

Indicator 8b – Community Trusts

Indicator 8b – Community Trusts	
Indicator name	Supporting Proactive and Safe Discharge – Community Providers
Indicator weighting (% of CQUIN scheme available)	0.25%
Description of Indicator	**Year 1 2017/18** • Part a) 60% of weighting for this measure. Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories. • Part b) 40% of weighting for this measure. Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17). Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate. **Year 2 2018/19** N/A
Numerator	**Year 1** Finished discharge episodes within Q3 and 4 of 2017/18, discharged to usual place of residence within 3- 7 days of admission of patients aged 65+ admitted via non-elective route. **Year 2** N/A
Denominator	**Year 1** Finished discharge episodes of patients aged 65+ admitted via non-elective route within Q3 and 4 with a LOS of >2. **Year 2** N/A
Rationale for inclusion	There is considerable evidence for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the ability of emergency departments to respond to people's needs, and increasing costs to local health

Indicator 8b – Community Trusts	
	economies. Unnecessary delay in discharging older patients from hospital is a systemic problem with a rising trend - between 2013 and 2015 recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million bed days[39]. For older people in particular, we know that longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs. Local A&E Delivery Boards are being asked in 2016/17 to implement key initiatives to address some of the major underlying issues causing delayed discharges. This CQUIN builds upon the 2016/17 A&E Plan discharge-specific activity to support systems to streamline discharge pathways, embed and strengthen the discharge to assess* pathway to maximum effect, and to understand capacity within community services to support improved discharge. This is a two year CQUIN that works across local health economies that aims to improve discharges for patients across all wards within hospitals. The desired outcomes will be improvement in patient outcomes, improvement in patient flow, and reduction in delayed discharges (and thus reduction in associated costs). Although this CQUIN includes a measure using acute data, it is an indicator of how well the whole system works to support timely discharge. Distribution of the CQUIN amount on achievement of the target between acute, community and NHS-commissioned care home beds would need to be determined locally. *Definition of discharge to assess[40]: Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where possible) or another community setting. This is where assessment for longer -term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Commonly used terms for this are: 'discharge to assess', 'home first', 'safely home', 'step down'.
Data source	HES / SUS

[39] National Audit Office, (2016) Discharging Older Patients from Hospital
[40] Quick Guide: Discharge to assess www.nhs.uk/quickguide

Indicator 8b – Community Trusts	
Frequency of data collection	Quarterly
Organisation responsible for data collection	HES data available via NHS Digital
Frequency of reporting to commissioner	Quarterly
Baseline period/date	**Year 1** Q3 and Q4 2016/17 **Year 2** N/A
Baseline value	
Final indicator period/date (on which payment is based)	**Year 1** End of 2017/18 **Year 2** N/A
Final indicator value (payment threshold)	**Year 1 (2017/18)** • 2.5% point increase discharge to usual place of residence: across Q3 and Q4 2017/18 OR an increase to 47.5% across Q3 and 4 2017/18. **Year 2 (2018/19)** N/A
Final indicator reporting date	Discharge to usual place of residence: **Year 1:** End of Q4 2017/18 **Year 2:** N/A
Are there rules for any agreed in-year milestones that result in payment?	Yes. See below.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes. See below.

Milestones for indicator 8b – Community Trusts

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Year 1 Part a)	(i) Map and streamline existing discharge pathways across acute, community and NHS-care home providers and roll-out protocols in partnership across local whole-systems. (ii) Develop and agree with commissioner a plan, baseline and trajectories which reflect impact of implementation of local initiatives to deliver the Part b indicator for year 1 and year 2. As part of this agree what proportion of the Part b indicator for each year will be delivered by the acute provider and what proportion will be delivered by the community provider. Achievement of part b will require collaboration between acute and community providers.	End of Q2 2017/18	60% of 100% in Year 1

Rules for partial achievement for indicator 8b – Community Trusts – part b)

This payment will be calculated on the combined total of provider and community contributions not on an individual provider performance.

Percentage point increase in discharge to usual place of residence
Year 1 (2017/18)

By the end of Q4 2.5% point increase from baseline in no. patients discharged to usual place of residence

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
Less than 1.5% point increase	No payment
1.5 up to 1.99% point increase	50% payment
2 up to 2.49% point increase	80% payment
2.5% point increase or greater	100% payment

Or

Year 1 (2017/18)

By the end of Q4 47.5% in % of patients discharged to usual place of residence

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
Less than 40%	No payment
40% up to 44.9%	50% payment
45% up to 47.4%	80% payment
47.5% or greater	100% payment

Indicator 8c – Care Homes

Indicator 8c – Care Homes	
Indicator name	Supporting Proactive and Safe Discharge – Care Homes
Indicator weighting (% of CQUIN scheme available)	0.25%
Description of Indicator	**Year 1 2017/18** Part a) 60% of weighting for this measure (applicable to acute, community and NHS commissioned care home bed providers). Actions to map existing discharge pathways and roll-out local protocols. Part b) 40% of weighting for this measure: • **Care Home Provider:** Locally agree collection of Patient Experience measure, or PROM for patients discharged to care home through D2A or metrics associated with delivery of part a. **Year 2 2018/19** Part a) 50% of weighting for this measure: • **Care Home Provider:** Collection and analysis of locally agreed patient Experience measure or PROM for patients discharged to care home through D2A or metrics agreed as per year one Part a. Part b) 50% of weighting for this measure: • **Care Home Provider:** To achieve Level 2 compliance of Information governance toolkit including adoption of secured email standard for transfer of personal information confidentially. This includes: 1. Collation of all paperwork and procedural documents required for IG toolkit compliance 2. IG Training of the all the staff in the processes and use of technology 3. Achievement of “satisfactory” grade Level 2 IG toolkit compliance and have a paperless information transfer system in place
Numerator	N/A
Denominator	N/A
Rationale for inclusion	There is considerable evidence for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, create financial pressures and impact on key

Indicator 8c – Care Homes	
	NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the ability of emergency departments to respond to people's needs, and increasing costs to local health economies. Unnecessary delay in discharging older patients from hospital is a systemic problem with a rising trend - between 2013 and 2015 recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million bed days[41]. For older people in particular, we know that longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs. Local A&E Delivery Boards are being asked in 2016/17 to implement key initiatives to address some of the major underlying issues causing delayed discharges. This CQUIN builds upon the 2016/17 A&E Plan discharge-specific activity to support systems to streamline discharge pathways, embed and strengthen the discharge to assess* pathway to maximum effect, and to understand capacity within community services to support improved discharge. This is a two year CQUIN that works across local health economies that aims to improve discharges for patients across all wards within hospitals. The desired outcomes will be improvement in patient outcomes, improvement in patient flow, and reduction in delayed discharges (and thus reduction in associated costs). Although this CQUIN includes a measure using acute data, it is an indicator of how well the whole system works to support timely discharge. Distribution of the CQUIN amount on achievement of the target between acute, community and NHS-commissioned care home beds would need to be determined locally. *Definition of discharge to assess[42]: Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where possible) or another

[41] National Audit Office, (2016) Discharging Older Patients from Hospital
[42] Quick Guide: Discharge to assess www.nhs.uk/quickguide

Indicator 8c – Care Homes	
	community setting. This is where assessment for longer - term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Commonly used terms for this are: 'discharge to assess', 'home first', 'safely home', 'step down'. Rationale for Year 2 update: Part b) Information Governance (IG) toolkit compliance and secured email standard for confidential information flow between NHS and care homes. Social care organisations are using a combination of different email systems with different levels of security. There is also a heavy reliance on fax and other paper-based methods for sending and receiving sensitive data with NHS organisations. Information shared by NHS Digital shows that **currently less than 1% of care providers have access to NHS mail**. Additionally local intelligence combined with NHS mail account data from NHS Digital suggests there is a **lack of coordinated engagement between the NHS and social care providers to develop local digital data sharing arrangements**. The benefits supporting care home providers to access and use secured email and compliance to the IG toolkit is that it will speed up safe and secure communications between organisations, support improvement of information flows, promote integrated working across all areas and lead to reduction in delayed transfer of care especially for patients waiting to be registered into a care setting and usual place of residence. This will not only help in improving the patient experience but also have clear financial benefits in regards to reduction of DToC rates. The future of an electronic NHS has been outlined in both the NHS Five Year Forward View , and the National Information Board's Personalised Health and Care 2020 Framework, acknowledging the need to move to the electronic transfer of confidential information. The safeguarding of confidential and sensitive information is a legal and regulatory requirement. There are many rules which surround the handling of information which Care homes must comply with, including 1. The Care Quality Commission (CQC) registration requirement. 2. The Data Protection Act 1998 which will be superseded by the General Data Protection

Indicator 8c – Care Homes	
	Regulation (GDPR) in May 2018 3. NHS Contracts with local NHS bodies with the CCG or Local Authorities include Information Governance requirements. One of the **pre-requisites to obtaining an NHS mail/secured email account is to have a valid IG Toolkit submission**. Care Homes must complete the voluntary sector IG toolkit in order to evidence and measure their compliance against the law and central guidance to ensure information is handled and protected correctly. It includes data security leadership obligations – people, processes and technology. All care homes are required to achieve and maintain a "satisfactory" grade in level two in all requirements. A grade of "satisfactory with improvement plan" is NOT sufficient. Guidance on how to achieve this and support for providers can be found via the following web links: https://www.igt.hscic.gov.uk/WhatsNewDocuments/Guidance%20for%20Care%20Homes%20on%20Completing%20their%20first%20IG%20Toolkit%20v2.0.pdf https://oacp.org.uk/wp-content/uploads/2017/12/An-Introduction-to-Information-Governance-for-Registered-Managers-V.1-July-17.pdf The toolkit is updated regularly. Providers should ensure they are completing the most recent version of the IGT and contact the IG team directly at https://www.igt.hscic.gov.uk/ContactUs.aspx if unsure.
Data source	**Year 1** Locally determined **Year 2** Part a) Locally determined Part b) 1) Collation of all paperwork and procedural documents required for IG toolkit compliance and 2) IG Training of the all the staff in the processes and use of technology - Locally determined 3) Achievement of Level 2 IG toolkit "satisfactory" grade for compliance and have a paperless information transfer system in place- all submissions can be seen on the IGT website by

Indicator 8c – Care Homes	
	searching for organisation name or code. (https://www.igt.hscic.gov.uk/ReportsOrganisationChooser.aspx?tk=431346910852909&lnv=3&cb=b1cf3cca-6a3f-4734-bbf0-2eb5941f88d4&reptypeid=1)
Frequency of data collection	Locally determined
Organisation responsible for data collection	Locally determined
Frequency of reporting to commissioner	**Year 1** Locally determined **Year 2** Part a) Locally determined **Year 2** Part b) 1) and 2) Locally determined **Year 2** Part b) 3) Commissioners to check the IGT website for achievement of the CQUIN
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	**Year 1:** End of 2017/18 **Year 2:** End of 2018/19
Final indicator value (payment threshold)	**Year 1 (2017/18):** See below table with milestones. **Year 2 (2018/19):** See below table with milestones.
Final indicator reporting date	**Year 1**: End of Q4 2017/18 **Year 2**: End of Q4 2018/19
Are there rules for any agreed in-year milestones that result in payment?	Yes, whenever the provider can show the completion of level 2 of Information Governance toolkit compliance with a “satisfactory” grade- all submissions can be seen on the IGT website
Are there any rules for partial achievement of the indicator at the final indicator period/date?	N/A

Milestones for indicator 8c – Care Homes

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Year 1 Part a)	Map and streamline existing discharge pathways across acute, community and NHS-care home providers and roll-out new protocols in partnership across local whole-systems.	End of Q2 2017/18	60% of 100% of Year 1
Part b)	Locally agree a patient experience measure or PROM for patients discharged to care home through D2A. Part b) Care home provider requirement or metrics associated with delivery of Part a.	End of Q4 2017/18	40% of 100% of Year 1
Year 2 Part a)	Collection and analysis of Patient Experience measure or PROM for patients discharged to care home through D2A (Minimum 100 Sample) or metrics associated with delivery of year 1 Part a.	End of Q2 2018/19 End of Q4 2018/19	50% of 100% of Year 2 50% of 100% of Year 2

9. Preventing ill health by risky behaviours – alcohol and tobacco

The CQUIN indicator 'Preventing ill health by risky behaviours – alcohol and tobacco' applies to Mental Health Trusts and Community Trusts in FY2017/18 and FY2018/19 (i.e. over two years). This indicator also applies to Acute Trusts in FY18/19 (i.e. over one year), although it is anticipated that Acute Trusts will begin planning activities in FY2017/18 to facilitate a smooth and effective delivery in FY2018/19.

There are five parts to this CQUIN indicator.

National CQUIN	Indicator	Indicator weighting (% of CQUIN scheme available)
CQUIN 9 - Tobacco	9a Tobacco screening	5% of 0.25% (0.0125%)
	9b Tobacco brief advice	20% of 0.25% (0.05%)
	9c Tobacco referral and medication offer	25% of 0.25% (0.0625%)
CQUIN 9 – Alcohol	9d Alcohol screening	25% of 0.25% (0.0625%)
	9e Alcohol brief advice or referral	25% of 0.25% (0.0625%)

Indicator 9a Tobacco screening

Indicator 9a	
Indicator name	Tobacco screening
Indicator weighting (% of CQUIN scheme available)	Achievement of target for this indicator attracts 5% of 0.25% (0.0125%). *(NB: this applies for Q2 onwards, different reward structure for Q1, see 'rules for in-year payment' section below).*
Description of Indicator	Percentage of unique adult patients who are screened for smoking status AND whose results are recorded.
Numerator	Number of **unique, adult patients** who are **admitted** and **screened for smoking status** and results are recorded in patient's record during this quarter: • **Unique** is defined as non-repeat admission of a patient during the duration of the CQUIN (ie FY 2017/18 and 2018/19) who has not already

Indicator 9a	
	received the intervention within the period of the CQUIN; • **Adult patient** is defined as patients of at least 18 years of age for the purpose of this CQUIN; • **Admitted** is defined as admitted to an inpatient ward for at least one night (ie Length of stay equal to or greater than one) **excluding** any admissions to maternity wards (ie admissions to maternity wards not in scope of this CQUIN). NB: screening should take place at a time that is clinically appropriate for the patient. For example, >7 days for patients with severe mental health illness as set out in the CQUIN for improving physical healthcare in people with severe mental health illness ('PSMI'); • The "**screened for smoking status**" element of this indicator requires the standard protocol for screening smokers in secondary care as per NICE guidance PH48 to be implemented. Detail on the required actions from healthcare professionals can be found on the National Centre for smoking Cessation and Training website (NCSCT). Secondary mental health providers in particular may want to build on the Lester tool as appropriate (which is also encouraged by the PSMI CQUIN). See Annex A for further details; and • The "**recorded in patient's record**" element of this indicator requires the delivery of the standard protocol as described above and the outcome to be recorded in the patient's record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information.
Denominator	All **unique, adult patients** who are **admitted** during this quarter: • **Unique** is defined as a non-repeat admission of a patient during the duration of the CQUIN (ie FY 17/18 and 18/19) who has not already received the intervention within the period of the CQUIN; • **Adult patient** is defined as patients of at least 18 years of age; and • **Admitted** is defined as admitted to an inpatient ward for at least one night (i.e. Length of stay equal to or greater than one) **excluding** any admissions to maternity wards (i.e. admissions to maternity wards not in scope of this CQUIN).

Indicator 9a	
Rationale for inclusion	**Context** This CQUIN seeks to help deliver on the objectives set out in the Five Year Forward View (5YFV), particularly around the need for a '…radical upgrade in prevention…' and to be '…incentivising and supporting healthier behaviour'. The proposal also supports delivery against the FYFV efficiency target by generating a projected national net cost-saving to the NHS over the course of the CQUIN. **The burden of smoking** Smoking is estimated to cost £13.8bn to society (£2bn on the NHS through hospital admissions, £7.5bn through lost productivity, £1.1bn in social care). Smoking is England's biggest killer, causing nearly 80,000 premature deaths a year and a heavy toll of illness, 33% of tobacco is consumed by people with mental health problems.[43] Smoking is the single largest cause of health inequalities.[44] A Cochrane Review[45] shows that smoking cessation interventions are effective for hospitalised patients regardless of admitting diagnosis. Inpatient smoking cessation leads to a reduced rate of wound infections, improved wound healing and increased rate of bone healing. Permanent smoking cessation reduces the risk of heart disease, stroke, cancer and premature death. The quit rates among patients who want to quit and take up a referral to stop smoking services are between 15% and 20%, compared to 3% to 4% amongst those without a referral.[46] **The status quo nationally** Coverage of advice and referral interventions for smokers are patchy. Currently in secondary care, some patients may be asked if they smoke, but not all, and not at every admission, e.g. less than half of smokers admitted to hospital receive very brief advice to stop as an inpatient. For those patients that have been identified as a smoker, this is no guarantee that they will then be given an effective stop smoking intervention and referral to evidence based smoking cessation support. Currently, only 1.5% of smokers in

[43] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf
[44] http://www.sciencedirect.com/science/article/pii/S0140673606689757
[45] Rigotti N, Munafo MR, Stead LF. Interventions for smoking cessation in hospitalised patients.Cochrane Database of Systematic Reviews 2007; Issue3.Art.No.:CD001837.DOI:10.1002/14651858.CD001837.pub2
[46] http://www.ncsct.co.uk/usr/pub/Briefing%208.pdf

Indicator 9a	
	acute hospital settings go onto make a quit attempt with stop smoking services. **The financial case** Modelling of the tobacco component of the CQUIN suggests that it could reduce costs through fewer admissions and improved health of smokers and passive smokers; resulting in net savings of £13 per patient referred to stop smoking support and prescribed Nicotine Replacement Therapy each year over 4 years. This is a conservative estimate accounting for the reduced cost of hospital admissions only.
Data source	**Provider audit of patient records, submitted to CCGs on a quarterly basis:** We propose that: • Providers with searchable electronic patient records audit **all patient records**. • Providers that do not have searchable electronic patient records conduct audits of a **random sample of patient records**. **The case notes in scope** of the audit are of all completed emergency and elective admissions (ie all inpatient admissions) with Length of Stay equal to or bigger than 1 day over the last three months. **The following exclusion criteria** should be applied: 1. All patients below 18 years of age. 2. All in-patients in maternity wards. 3. All A&E attendances that do not lead to in-patient admissions. 4. All repeat admissions during the duration of the CQUIN (ie FY 17/18 and 18/19) of patients who have already received the intervention. **For audits based on samples** of the eligible patient records, it is suggested that they identify a random sample, an appropriate sample size and an appropriate method for conducting the review. Additional guidance on sampling is provided in Annex B. **The sampling method** used should seek to ensure that a cross-section of appropriate wards is represented in the sample. Audits to be undertaken

Indicator 9a	
	by provider performance and insight teams. **Patient records should be clear and consistent** in the way that the individual components of the CQUIN actions are recorded to enable uniform collection across the provider. It is the responsibility of providers to identify the most effective way of recording the required information and communicating this to relevant staff[47].
Frequency of data collection	**Quarterly**. Data to be collected ahead of quarterly audit. Note that the data that is required for the audits are patient case notes, which are to be updated by staff whenever relevant.
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	**Quarterly** Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via NHS Digital SDCS on a quarterly basis as well.
Baseline period/date	Baseline set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below.
Baseline value	To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below.
Final indicator period/date (on which payment is based)	Quarter 4 FY 18/19.
Final indicator value (payment threshold)	**90%**
Final indicator reporting date	As soon as possible after Q4 2018/19.
Are there rules for any agreed in-year milestones that result in payment?	Yes **Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice; and c) collecting baseline data. Payment

[47] Note that staff and healthcare professionals are used interchangeably throughout this document. The intention is to ensure that the intervention is delivered by the most appropriate healthcare professionals and is not restricted to one particular professional group. Providers will be best placed to judge who in their organisations should deliver.

Indicator 9a	
	is split equally between a), b) and c), for more detail see *Milestones* below. **Quarter 2 and onwards** – payment is available for high (i.e. to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see *Rules for partial achievement* below.

Indicator 9b Tobacco brief advice

Indicator 9b	
Indicator name	Tobacco brief advice
Indicator weighting (% of CQUIN scheme available)	Achievement of target for this indicator attracts 20% of 0.25% (0.05%). *(NB: this applies for Q2 onwards, different reward structure for Q1: see 'rules for in-year payment' section below).*
Description of Indicator	Percentage of unique patients who smoke AND are given very brief advice.
Numerator	Number of **eligible patients** who are **given brief advice** during this quarter: • **Eligible patients** are defined as patients who have been recorded as smokers during screening (in 1a); and • The "**given very brief advice**" element of this indicator requires healthcare professionals to provide a brief advice message and for this to be recorded in the patient's record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information. Detail on the required actions from staff can be found on the National Centre for smoking Cessation and Training website (NCSCT). Secondary mental health providers in particular may want to build on the Lester tool as appropriate. See Annex A for further details.
Denominator	All **eligible patients** during this quarter: • **Eligible patients** are defined as patients who have been recorded as smokers during screening (in 9a).
Rationale for inclusion	Please refer to this section in 9a.
Data source	Please refer to this section in 9a.
Frequency of data collection	**Quarterly**. Data to be collected ahead of quarterly audit. Note that the data that is required for the audits are patient case notes which are to be updated by staff whenever relevant.
Organisation responsible for data	**Provider**.

Indicator 9b	
collection	
Frequency of reporting to commissioner	**Quarterly**. Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via NHS Digital SDCS on a quarterly basis as well.
Baseline period/date	Baseline set during Q1 of the CQUIN (i.e. Q1 of FY 2017/18); see *Milestones* below.
Baseline value	To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below.
Final indicator period/date (on which payment is based)	Quarter 4 FY 2018/19.
Final indicator value (payment threshold)	**90%**
Final indicator reporting date	As soon as possible after Q4 2018/19
Are there rules for any agreed in-year milestones that result in payment?	Yes. **Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice; and c) collecting baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below. **Quarter 2 and onwards** – payment is available for high (i.e. to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see *Rules for partial achievement* below.

Indicator 9c Tobacco referral and medication offer

Indicator 9c	
Indicator name	Tobacco referral and medication offer
Indicator weighting (% of CQUIN scheme available)	Achievement of target for this indicator attracts 25% of 0.25% (0.0625%). *(NB: this applies for Q2 onwards, different reward structure for Q1, see 'rules for in-year payment' section below).*
Description of indicator	The percentage of unique patients who are smokers AND are referred to stop smoking services AND offered stop smoking medication.
Numerator	Number of **eligible patients** who are **referred** to specialist services and **offered stop smoking medication** during this quarter: • **Eligible patients** are defined as patients who have been recorded as smokers during screening (in 1a); • The "**referred**" element of this indicator requires healthcare professionals to refer patients (not just signposting) to stop smoking services (these could be eg Local Authority funded Local Stop Smoking Services or lifestyle service in the community; in-house services in hospital; or within GP practices or pharmacies) and this to be recorded in the patient's record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information. Detail on the required actions from staff can be found on the National Centre for smoking Cessation and Training website (NCSCT). Secondary mental health providers in particular may want to build on the Lester tool as appropriate. See Annex A for further details; and • The "**offered stop smoking medication**" element of this indicator requires healthcare professionals to offer medication (where this is medically appropriate and possible) and this to be recorded in the patient's record in a clear and consistent way. This should be accompanied where relevant by behavioural support as per NICE guidance. Secondary mental health providers in particular may want to build on the Lester tool as appropriate.
Denominator	All **eligible patients** during this quarter: • **Eligible patients** are defined as patients who have

Indicator 9c	
	been recorded as smokers during screening (in 9a)
Rationale for inclusion	Please refer to this section in 9a.
Data source	Please refer to this section in 9a.
Frequency of data collection	**Quarterly**. Data to be collected ahead of quarterly audit. Note that the data that is required for the audits are patient case notes which are to be updated by staff whenever relevant.
Organisation responsible for data collection	**Provider**
Frequency of reporting to commissioner	**Quarterly** Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via NHS Digital SDCS on a quarterly basis as well.
Baseline period/date	Baseline set during Q1 of the CQUIN (i.e. Q1 of FY 2017/18); see *Milestones* below.
Baseline value	To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below.
Final indicator period/date (on which payment is based)	Quarter 4 FY 2018/19.
Final indicator value (payment threshold)	**30%**
Final indicator reporting date	As soon as possible after Q4 2018/19.
Are there rules for any agreed in-year milestones that result in payment?	Yes. **Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collecting baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below. **Quarter 2 and onwards** – payment is available for high (ie to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment.

Indicator 9c	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see *Rules for partial achievement* below.

Indicator 9d Alcohol screening

Indicator 9d	
Indicator name	Alcohol screening
Indicator weighting (% of CQUIN scheme available)	Achievement of target for this indicator attracts 25% of 0.25% (0.0625%)**.** *(NB: this applies for Q2 onwards, different reward structure for Q1, see 'rules for in-year payment' section below)*
Description of indicator	Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems.
Numerator	Number of **unique, adult patients** who are **admitted** and **screened for alcohol consumption** and results are **recorded in patient's record** during this quarter: • **Unique** is defined as non-repeat admission of a patient during the duration of the CQUIN (ie FY 2017/18 and 2018/19) who has not already received the intervention within the period of the CQUIN; • **Adult patient** is defined as patients of at least 18 years of age for the purpose of this CQUIN; • **Admitted** is defined as admitted to an inpatient ward for at least one night (ie Length of stay equal to or greater than one) **excluding** any admissions to maternity wards (ie admissions to maternity wards not in scope of this CQUIN). NB: screening should take place at a time that is clinically appropriate for the patient. For example, >7 days for patients with severe mental health illness as set out in the PSMI CQUIN; • The "**screened for alcohol consumption**" element of this indicator requires the standard protocol for alcohol screening in secondary care as per NICE guidance to be implemented. Detail on the required actions from staff can be found on the NICE website. Secondary mental health providers in particular may want to build on the Lester tool to include an appropriate alcohol component (which is also encouraged by the PSMI CQUIN). See Annex A for further details; and • The "**recorded in patient's record**" element of this indicator requires the delivery of the standard protocol as described above and the outcome to be recorded in the patient's record in a clear and consistent way. It is the responsibility of providers

Indicator 9d	
	to identify the most effective way of recording this information.
Denominator	All **unique, adult patients** who are **admitted** during this quarter: • **Unique** is defined as non-repeat admission of a patient during the duration of the CQUIN (ie FY 2017/18 and 2018/19) who has not already received the intervention within the period of the CQUIN. • **Adult patient** is defined as patients of at least 18 years of age; and • **Admitted** is defined as admitted to an inpatient ward for at least one night (i.e. Length of stay equal to or greater than one) **excluding** any admissions to maternity wards (i.e. admissions to maternity wards not in scope of this CQUIN).
Rationale for inclusion	**Context** This CQUIN seeks to help deliver on the objectives set out in the Five Year Forward View (5YFV), particularly around the need for a '…radical upgrade in prevention…' and to be '…incentivising and supporting healthier behaviour'. The proposal also supports delivery against the FYFV efficiency target by generating a projected national net cost-saving to the NHS over the course of the CQUIN. **The burden of excessive alcohol consumption** In England, 25% of the adult population (33% of men and 16% of women) consume alcohol at levels above the UK CMOs' low-risk guideline and increase their risk of alcohol-related ill health. [48] Alcohol misuse contributes (wholly or partially) to 60 health conditions leading to hospital admission, due either to acute alcohol intoxication or to the toxic effect of alcohol misuse over time. Conditions include cardiovascular conditions, liver disease, cancers, depression and accidental injuries.[49] There are nearly 22,500 alcohol-attributable deaths per year.[50] Out of c3.7m admissions[51], c333,000 were admissions where an alcohol-related disease, injury or condition was the primary diagnosis or there was an

[48] http://digital.nhs.uk/catalogue/PUB16076
[49] http://www.hscic.gov.uk/catalogue/PUB13218/HSE2012-Ch6-Alc-cons.pdf
[50] Public Health England (2016), Local Alcohol Profiles for England. Available at: http://fingertips.phe.org.uk/profile/local-alcohol-profiles
[51] Admissions to acute, acute &community and acute specialist providers in 2014/15, excluding maternity and below 18s, based on HES data

Indicator 9d	
	alcohol-related external cause. These alcohol-related admissions are 32% higher than in 2004/05.[52] Alcohol is estimated to cost the public purse £21bn per annum, of which £3.5bn are costs to the NHS. Around three quarters of the £3.5bn cost to the NHS is incurred by people who are not alcohol dependent, but whose alcohol misuse causes ill health – this is the group for which IBA is the most effective. Identification and Brief Advice (IBA) results in recipients reducing their weekly drinking by c12%. Because alcohol health risk is dose dependent, reducing regular consumption by any amount reduces the risk of ill health. **The status quo nationally** Currently, IBA delivery in secondary care is patchy and nowhere near the optimal large scale delivery required to significantly impact on population health. It is strongest where there are strong Making Every Contact Count (MECC) initiatives that include alcohol IBA and where there are well-resourced alcohol care teams that train other staff. **The financial case** Alcohol identification and brief advice is effective in reducing health risk from drinking in non-dependent drinkers. The successful delivery of the CQUIN is estimated to bring about a reduction of weekly alcohol consumption of 12%, which could result in net savings of c£27 per patient receiving alcohol brief advice each year over 4 years, from reduced alcohol-related hospital admissions following improvements in morbidity. (NB: these figures are taken from unpublished modelling conducted by Sheffield University using data derived from the latest Cochrane review of brief advice in primary care.[53])
Data source	**Provider audit of patient records, submitted to CCGs on a quarterly basis:** We propose that: • Providers with searchable electronic patient records audit **all patient records**. • Providers that do not have searchable electronic patient records conduct audits of a **random**

[52] Statistics on Alcohol, England, 2016 (NHS Digital, 2016)
[53] Kaner EFS, Beyer F, Dickinson HO, Pienaar E, Campbell F, Schlesinger C, et al. Effectiveness of brief alcohol interventions in primary care populations. Cochrane database Syst Rev Online. Wiley Online Library; 2007; 4(2):CD004148.

Indicator 9d	
	sample of patient records. **The case notes in scope** of the audit are of all completed emergency and elective admissions (ie all inpatient admissions) with Length of Stay equal to or bigger than 1 day over the last three months. **The following exclusion criteria** should be applied: 1. All patients below 18 years of age. 2. All in-patients in maternity wards. 3. All A&E attendances that do not lead to in-patient admissions. 4. All repeat admissions during the duration of the CQUIN (i.e. FY 2017/18 and 2018/19) of patients who have already received the intervention. **For audits based on samples** of the eligible patient records, it is suggested that they identify a random sample, an appropriate sample size and an appropriate method for conducting the review. Additional guidance on sampling is provided in Annex B. **The sampling method** used should seek to ensure that a cross-section of appropriate wards is represented in the sample. Audits to be undertaken by provider performance and insight teams. **Patient records should be clear and consistent** in the way that the individual components of the CQUIN actions are recorded to enable uniform collection across the provider. It is the responsibility of providers to identify the most effective way of recording the required information and communicating this to relevant staff.
Frequency of data collection	**Quarterly**. Data to be collected ahead of quarterly audit. Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via NHS Digital SDCS on a quarterly basis as well.
Organisation responsible for data collection	**Provider**
Frequency of reporting to commissioner	**Quarterly** Note that to enable national audits, providers will simultaneously submit this data to NHS England via NHS

Indicator 9d	
	Digital SDCS on a quarterly basis as well.
Baseline period/date	Baseline set during Q1 of the CQUIN (i.e. Q1 of FY 2017/18); see *Milestones* below.
Baseline value	To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below.
Final indicator period/date (on which payment is based)	Quarter 4 FY 2018/19.
Final indicator value (payment threshold)	**50%**
Final indicator reporting date	As soon as possible after Q4 2018/19.
Are there rules for any agreed in-year milestones that result in payment?	Yes. **Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice; and c) collecting baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below. **Quarter 2 and onwards** – payment is available for high (ie to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see *Rules for partial achievement* below.

Indicator 9e Alcohol brief advice or referral

Indicator 9e	
Indicator name	Alcohol brief advice or referral
Indicator weighting (% of CQUIN scheme available)	Achievement of target for this indicator attracts 25% of 0.25% (0.0625%). *(NB: this applies for Q2 onwards, different reward structure for Q1, see 'rules for in-year payment' section below)*
Description of Indicator	Percentage of unique patients who drink alcohol above low-risk levels AND are given brief advice OR offered a specialist referral if the patient is potentially alcohol dependent.
Numerator	Number of **eligible patients** who are **given brief advice** or offered a referral to specialist alcohol services(if the patient is potentially alcohol dependent) during this quarter: • **Eligible patients** are defined as patients who have been recorded as drinking above the low risk levels during screening (in 2a); • The "**given brief advice**" element of this indicator requires the healthcare professional to provide a brief advice message and this to be recorded in the patient's record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information. Detail on the required actions from staff can be found on the NICE website. See Annex A for further details; • The "**offered a specialist referral if the patient is potentially alcohol dependent**" element of this indicator is only required in instances where screening indicates potential alcohol dependence and the referral is instead of brief advice provision. It requires the health professional to offer a referral (not just signposting) for specialist alcohol assessment by the hospital alcohol care team or a local community alcohol treatment service and this to be recorded in the patient's record in a clear and consistent way. Detail on the required actions from staff can be found on the NICE website. See Annex A for further details.
Denominator	All **eligible patients** during this quarter: • **Eligible patients** are defined as patients who have been recorded as drinking above the low risk limits during screening (in 9d).
Rationale for inclusion	Please refer to this section in 9d.
Data source	Please refer to this section in 9d.

Indicator 9e	
Frequency of data collection	**Quarterly** Data to be collected ahead of quarterly audit. Note that the data that is required for the audits are patient case notes which are to be updated by health practitioners whenever relevant.
Organisation responsible for data collection	**Provider**
Frequency of reporting to commissioner	**Quarterly** Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via NHS Digital SDCS on a quarterly basis as well.
Baseline period/date	Baseline set during Q1 of the CQUIN (ie Q1 of FY 2017/18); see *Milestones* below.
Baseline value	To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below.
Final indicator period/date (on which payment is based)	Quarter 4 FY 2018/19.
Final indicator value (payment threshold)	**80%**
Final indicator reporting date	As soon as possible after Q4 2018/19.
Are there rules for any agreed in-year milestones that result in payment?	Yes **Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice; and c) collecting baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below. **Quarter 2 and onwards** – payment is available for high (i.e. to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see *Rules for partial achievement* below.

Milestones for indicators 9a-9e (Note: these only apply to Q1 of the CQUIN)

For Community and Mental Health Providers this means that they will be rewarded in:

a) Quarter 1 of FY17/18 for achievement of the three milestones set out below; and
b) Quarter 2 (and any subsequent quarters in FY 2017/18 and FY 2018/19) according to performance across the indicators (partial payment rules set out below apply for Q2 FY 2017/18 and onwards).

For Acute Providers this means that they will be rewarded in

a) Quarter 1 of FY 2018/19 for achievement of the three milestones set out below (this is because the CQUIN only applies to Acute providers from FY 2018/19 onwards); and
b) Quarter 2 of FY 2018/19 (and any subsequent quarters in FY 18/19) according to performance across the indicators (partial payment rules set out below apply for Q2 FY 2018/19 and onwards).

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
End Quarter 1	Completed information systems audit This milestone requires each provider to undertake an audit its existing information systems. This audit needs to set out: 1. What the proposed mechanisms for collecting the required data for the indicators are / will be for the respective provider 2. What (if any) changes have been made to the data capturing arrangements / information in order to enable the quarterly case note audits 3. The proposed approach for conducting the quarterly case note audits (this should include details on potential data quality issues and any other risks; and set out mitigating actions for these to ensure that the case note audits yield accurate data on performance).	31 July 2017	33% of Q1 CQUIN funds

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	The audit needs to be shared with the commissioner by the reporting deadline (31 July 2017). Commissioners are responsible for ensuring that the audit meets the requirements set out above. Full payment of the CQUIN should be provided for audits that address all the requirements set out above. Audits that do not address all requirements will not attract payment.		
End Quarter 1	**Completed brief advice training for relevant staff** This milestone requires each provider to establish and implement a brief advice training plan for relevant health professionals who are expected to provide brief advice. Providers will demonstrate achievement of this milestone by drafting a report which needs to contain details on: 1. **A status quo capacity assessment** (ie identification of who the relevant health professionals are to deliver brief advice and an assessment of the existing skills of those relevant health professionals to deliver brief advice). 2. **Who** is in scope to receive the training (ie based on the capacity assessment, identify individual or groups of health professionals who would require training; and clinical leader(s) to act as ward or hospital "champions"). 3. **What** the training entails (ie what components are included in the training, how is it sourced and who is to deliver	31 July 2017	33% of Q1 CQUIN funds

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	the training including the method of delivery). 4. **How** effective the training has been (ie assessment of how effective the training was through e.g. Self-assessment of participants after training completion). 5. **When** the training has been delivered (ie training schedule and what groups were trained when; what processes are in place to deliver training for new starters; what process is in place to ensure that training is refreshed; it is expected that the majority of the training is completed by the end of Q1 but where this is not possible, plans for future training are required). The report needs to be shared with the commissioner by the reporting deadline (31 July 2017). Commissioners are responsible for ensuring that the report meets the requirements set out above. Full payment of the CQUIN should be provided for reports that address all the 5 requirements set out above. Reports that do not address all requirements will not attract payment.		
End Quarter 1	**Collected relevant data to establish baseline for all indicators** This milestone requires each provider to collect the required data for each indicator of the CQUIN to establish a baseline performance level. Full payment of the CQUIN should be awarded to those organisations that can establish a credible baseline level	31 July 2017	33% of Q1 CQUIN funds

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	of performance across all indicators. Where baseline data is not available for all of the indicators, no payment will be made. Note that in exceptional cases where providers may not be able to establish baseline data in Q1, they may – following agreement with providers – be able to establish their baseline in Q2 in order to participate in future quarters of the CQUIN.		

Rules for partial achievement of indicator 9a-e (note that these apply from Q2 onwards)

	% of CQUIN scheme available for meeting final indicator value				
Final indicator value for the partial achievement threshold	**9a**	**9b**	**9c**	**9d**	**9e**
100%	**5%**	**20%**	**25%**	**25%**	**25%**
for those achieving below 100% of target / final indicator value					
10% point improvement over last Q performance*	**2%**	**10%**	**12%**	**12%**	**12%**
20% point improvement over last Q performance*	**4%**	**15%**	**18%**	**18%**	**18%**

*Note that following the baseline setting exercise in Q1, a minimum threshold level of activity may be introduced such that improvements only over this minimum threshold would be partially rewarded.

Annex A – Supplementary Guidance

Supplementary guidance will be issued alongside this final CQUIN guidance document. This supplementary guidance will be targeted at and co-developed by frontline healthcare professionals and contain a comprehensive suite of resources for them to facilitate successful delivery of the CQUIN.

Annex B – Method for identifying random samples and minimum sample sizes

Trusts should select ONE of the following methods and maintain this method throughout the 2016/7 year of data collection:

1. True randomisation: review the n^{th} patient's notes where n is generated by a random number generator or table (eg http://www.random.org/) and this is repeated until a full sample of notes has been reviewed. These are easy to use and readily available online – eg http://www.random.org/

2. Pseudo-randomisation: Review the first X patients' notes where the day within the date of birth is based on some sequence eg start with patients born on the 1^{st} of the month, move to 2^{nd}, then 3^{rd}, until X patients have been reviewed. X equals the sample size required. Note this must NOT be based on full birthdate as this would skew the sample to particular age groups.

Feedback from analysts and the engagement exercise was received relating to the required sample size for sample-based patient record audits:

3. Due to expected attrition with each step of the interventions (from screening, to brief advice, to referral) and the need to provide robust samples, feedback from stakeholders suggested that a minimum sample size for sample-based audits should be set.

4. The minimum sample size is initially set at 500 case notes per quarter. Those trusts that receive fewer than 500 eligible patients per quarter should audit all eligible patient records. Those trusts that receive more than 500 eligible patients per quarter should ensure that their sample is random and may follow the methods set out above to achieve randomisation.

5. National bodies will continue to keep issues related to data collection including minimum sample sizes under review. There will also be additional advice for trusts on how they can reduce the administrative burden as part of supplementary guidance.

10. Improving the assessment of wounds

Indicator	
Indicator name	Improving the assessment of wounds
Indicator weighting (% of CQUIN scheme available)	0.25%
Description of indicator	The indicator aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.
Numerator	**Year 1** Number of patients who have a completed full wound assessment (all criteria assessed and documented) within Q2 & Q4 2017/18. **Year 2** Number of patients who have a completed full wound assessment (all criteria assessed and documented) within Q2 & Q4 2018/19.
Denominator	**Year 1** Number of patients on the provider's caseload with wounds that have failed to heal for 4 weeks or more following self-care, primary, community or specialist care within Q2 & Q4 2017/18. **Year 2** Number of patients on the provider caseload with wounds that have failed to heal for 4 weeks or more following self-care, primary, community or specialist care within Q2 & Q4 2018/19.
Rationale for inclusion	Research evidence demonstrates that over 30% of chronic wounds (wounds that have failed to heal for 4 weeks or more) do not receive a full assessment which is based on research evidence and best practice guidelines. Failure to complete a **full** assessment can result in ineffective treatment and contributes to delays in the rate of wound healing for patients. This has significant consequences for patients in respect of their quality of life as failure to treat wounds correctly can lead to delays in healing or failure to heal. For providers and commissioners the delay in wound healing relates to the resources being consumed inappropriately. Managing patients with wounds and their associated co-morbidities is estimated to cost the NHS £5.3 billion; the average cost of unhealed wounds is more than double that of healed wounds. There is also significant variation in current practice. A recent economic evaluation of a wound care pathway for chronic wounds demonstrates that the current pathway experienced by many patients delivers poorer outcomes at greater cost to the commissioner – the study estimates this cost

Indicator	
	to be approximately 10 times greater. Increasing the number of patients who have a full assessment of chronic wounds will promote the use of effective treatment based on the outcome of the assessment. The aim in 2018/19 is for providers to achieve a national target of a minimum 80% completion of full wound care assessments.
Data source	Local baseline audit collection of a minimum of 150 patients on the caseload with a wound that has failed to heal within 4 weeks, which will then be submitted through a national data collection via NHS Digital. Information available at: http://content.digital.nhs.uk/article/7751/Commissioning-for-Quality-and-Innovation-CQUIN If the provider is providing care for less than 150 patients on their caseload then all patients who have a wound that has failed to heal within 4 weeks should be included in the audit.
Frequency of data collection	6 monthly through Q2 & Q4 Clinical Audit (both Year 1 and Year 2)
Organisation responsible for data collection	Community Service Provider
Frequency of reporting to commissioner	Quarterly through clinical audit report (Q2 & Q4) and improvement plan.
Baseline period/date	**Year 1** Q2 2017/18 **Year 2** Q4 2017/18
Baseline value	**Year 1** To be determined by outcome of Q2 2017/18 clinical audit undertaken by Community Service provider. **Year 2** To be determined by outcome of Q4 2017/18 clinical audit undertaken by Community Service Provider.
Final indicator period/date (on which payment is based)	Q4 2018/19
Final indicator value (payment threshold)	**Year 1** Payment to be based upon establishing the baseline in Q2 and on achieving locally agreed levels of improvement against that baseline for Q4. **Year 2**

Indicator	
	Payment to be based upon achieving 60% of full wound assessment completion for Q2 and on achieving 80% of full wound assessment completion for Q4. Providers with a baseline (from Q2 2017/18) > 80% should be assessed in accordance with the table included in the partial payments section below.
Final indicator reporting date	31 May 2019
Are there rules for any agreed in-year milestones that result in payment?	Yes – see table below.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see table below

Milestones

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1 and 2 2017/18	Completion of Clinical audit to provide a baseline figure for the number of patients with chronic wounds that have received a full assessment. Full audit report and improvement plan with trajectory to be provided for commissioner.	30 November 2017	50% of year if baseline data collection established and improvement plan agreed.

Quarter 4 2017/18	Completion of clinical audit to demonstrate an improvement in the number of patients with chronic wounds who have received a full wound assessment.	30th April 2018	Maximum of 50% of year available based on the following achievement of locally agreed levels of improvement in the number of patients with chronic wounds who have received a full wound assessment:
Quarter 2 2018/19	Completion of Clinical Audit to demonstrate an improvement to a minimum of 60% of patients with chronic wound who have received a full wound assessment.	31st October 2018	50% of year if a minimum of 60% of chronic wounds have a full wound assessment and an improvement plan is agreed.
Quarter 4 2018/19	Completion of clinical audit to demonstrate an improvement in the number of patients with chronic wounds who have received a full wound assessment to a minimum of 80%.	30th April 2019	Maximum of 50% of year available based on the following achievement of minimum of 80% of patients with chronic wounds who have received a full wound assessment:

Rules for partial achievement of indicator 10

Quarter 4: 2017/18

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
Achieved less than 33% of improvement target:	No payment
33-99.9% of target:	15%
100% or above:	50%

Quarter 2: 2018/19

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
Achieved less than 50%	No payment
50 - <60%	20%
60 - 100%	50% (max payment)

Quarter 4: 2018/19

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
Achieved less than 60%	No payment
60 - <80%	20%
80 - 100%	50% (max payment)

For providers with a baseline (from Q2 2017/18) > 80%, the approach below applies for both Quarter 2 and Quarter 4 2018/19 and should be applied instead of the partial payment threshold outlined above

Final indicator value for providers with a baseline >80%	% of CQUIN scheme available for meeting final indicator value
<70%	No payment
70% - <80%	20%
80% - <90%	40%
>90%	50% (max payment)

References

Guest JF, Ayoub N, McIlwraith T, *et al*. Health economic burden that wounds impose on the National Health Service in the UK. *BMJ Open* 2015;5: e009283. doi:10.1136/bmjopen-2015-009283

11. Personalised care and support planning

Indicator 11	
Indicator name	Personalised Care and Support Planning
Indicator weighting (% of CQUIN scheme available)	0.25%
Rationale	More than half of the population live with long term conditions and 5% of these people account for more than 75% of unscheduled hospital admissions. Many of these people (35%) indicate they have low or very low levels of knowledge, skills and confidence to self-care, in order to manage their health and wellbeing and live independently. These people have a poorer quality of life, make more unwarranted use of public services and cost more to public services. Changing this situation is not a short-term fix. There are, however, steps we can take, supported by the CQUIN scheme to incentivise the change in behaviours and methodologies that allow patients to take greater control over their health and wellbeing. A core component is personalised care and support planning which is; a) an intervention that supports people to develop the knowledge, skills and confidence to manage their own health and wellbeing and that leads to the development of a care plan and b) an enabler that supports patients to understand the local support mechanisms that are available to them. We envisage that the first year of the CQUIN is an opportunity to introduce the requirement of high quality personalised care and support planning, whilst recognising that not all health systems will have the technological means nor the workforce capabilities of making these happen. In future years there will be a need to increase the expected levels of achievement so that by 2020/21 personalised care and support planning is fully embedded across the service as the norm. The Realising the Value report 'At the heart of health' describes how personalised care and support planning is a key enabler to allow the proliferation of self-care support packages such as health coaching, peer support and self-management education. In this context it can be seen as the foundation for the behaviour change needed to support improvements in self-care.
Description of Indicator	This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long-term conditions. In the first year, activity will be focused on agreeing and putting in place systems and processes to ensure that the relevant patient population can be

Indicator 11	
	identified, the relevant workforce receives appropriate training, and that personalised care and support planning conversations can be incorporated into consultations with patients and carers. The second year will focus more on delivery of personalised care and support planning, the quality of conversations and the impact on individual levels of knowledge, skills and confidence. **Year 1 – 2017/18** In year one there are three components: **1: Establishing provider systems** to ensure that personalised care and support planning conversations can be incorporated into care delivery and can be recorded as an activity. Also to ensure relevant cohorts of patients who would benefit most from the delivery of personalised care and support planning can be identified on IT systems. For the purpose of the CQUIN, personalised care and support planning conversations are defined as: • *Conversations between a care professional, a person with long-term conditions and their carer (if applicable) to understand what is important to that individual and what support they need in order to help build their knowledge, skills and confidence to manage their health and wellbeing.* • *Follow a process of sharing information, identifying support needs, discussing options, contingency planning, setting goals, developing an action plan, and monitoring progress.* • *Consider how to co-ordinate the individual's care across a number of different care settings, linking to other existing care plans, particularly for people with multiple conditions.* • *Consider physical and mental health as well as wider holistic wellbeing.* • *Resulting in an agreed, recorded, document that the patient and carer owns.* Providers should develop and agree a plan outlining their approach to delivering personalised care and support planning and how this will be recorded as an activity, taking account of the pioneering work of the national Integrated Personal Commissioning team, the latest iteration of the TLAP personalised care and support planning tool[54] and the NHS England handbook on personalised care and support planning[55].

[54] http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/
[55] NHS England & Coalition for Collaborative Care (2015) *Personalised care and support planning handbook* - https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/

Indicator 11	
	2: Identifying relevant patient populations. Providers should develop and agree a plan outlining how they will identify the relevant patient population with one or more long-term conditions and with low levels of knowledge, skills and confidence (activation) to manage their health and wellbeing who would benefit from personalised care and support planning. They will need to take into consideration cohorts of patients who may already be participating in personalised care and support planning, for example people with learning disabilities, people with severe mental health issues who are part of the Care Programme Approach, people with complex needs who have personal health budgets or are part of the Integrated Personal Commissioning programme. This may require planning with commissioners and other providers to agree who will lead the care planning process, and also how multi-disciplinary teams can work together. To identify the cohort providers should: • Identify patients with one or more long-term conditions as defined by the GP patient survey (see below). People may be identified on clinical IT systems, for example using ICD10 codes or using risk stratification tools. People may be additionally identified through contact with care professionals as someone who would benefit from personalised support[56]. The list of long-term conditions defined in the GP patient survey is: • Alzheimer's disease or dementia • Angina or long-term heart problem • Arthritis or long-term joint problem • Asthma or long-term chest problem • Blindness or severe visual impairment • Cancer in the last 5 years • Deafness or severe hearing impairment • Diabetes • Epilepsy • High blood pressure • Kidney or liver disease • Long-term back problem • Long-term mental health problem • Long-term neurological problem Then **conduct a baseline review of patient activation** for those patients with long term conditions identified above. This

[56] See also NICE guideline on multimorbidity - https://www.nice.org.uk/guidance/ng56

Indicator 11	
	means: • For those organisations already using the Patient Activation Measure, ensuring that all identified patients and carers have their activation levels recorded[57]; this can be combined to create an organisational score, or • For those organisations not using the Patient Activation Measure, ensuring that all identified patients and carers are asked a local survey using two key questions from the existing GP patient survey (GPPS). Answers to these questions will use the same criteria as the GPPS and be given scores as described below to allow production of an organisational score. These are: ○ **Q32** – *In the last six months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?* Answering 'yes, definitely' = 1 point, 'yes, to some extent' = 0.5 points. Other answers = 0 points ○ **Q33** – *How confident are you that you can manage your own health?* Answering 'very confident' = 1 point, 'fairly confident' = 0.5 points. Other answers = 0 points. **Following this review of patient activation, the relevant population to be prioritised for personalised care and support planning will be defined as:** • A cohort of patients with one or more long-term conditions as defined by the GP patient survey[58]; **and** • For those organisations already using the Patient Activation Measure those patients assessed at Level 1 or 2 in their activation level; **or** • For those organisations not using the Patient Activation Measure, those patients who score 0 points on the GPPS questions. (see **Annex A** for further guidance) **Note**: For Year 2, the provider will identify and agree a revised Cohort with the commissioner. This cohort will be drawn from the Year 1 Cohort and will thus be a sub-group of those patients

[57] Patient Activation Best Practice Guide (due to be published December 2016)
[58] Final position to be confirmed prior to April 2017. The current expectation is this will include a broad definition (Long term conditions are health conditions that can't be cured, last a year or longer, impact on a person's life, and may require on-going care and support) and a list of the specific conditions that fall under this definition

Indicator 11	
	who need further support in patient activation. Please see **Annex A** for guidance on Year 2 Cohort selection. **3: Ensuring that all relevant provider staff are sufficiently competent** in holding care and support planning discussions with patients and carers, through appropriate training. For the purpose of the CQUIN 'relevant provider staff' can be defined as: • *Those who have allocated time to support the patient and carer to develop their care and support plan; and* • *Have specific expertise or training in support for people with long-term conditions; and* • *Are in a position to be able to liaise with multidisciplinary teams as required to gather information pertinent to the care planning discussion, and to raise issues that are impacting on an individual's care or that need to be considered at an organisational level.* • *Are a regular (at least annual) point of contact for the patient and carer.* Appropriate training is defined as training that: • *Explores the role of care & support planning in empowering patients and carers;* • *Clearly defines the role and expectations of the member of staff and the patient and/or carer;* • *Provides a framework for staff to follow in having structured care and support planning conversations based around what is important to the person living with a long-term condition and their holistic needs, not just their medical needs;* • *Helps staff develop skills in motivational interviewing to help them in encouraging patients and carers to actively participate in planning discussions, and how to tailor their approach based on the individual's levels of knowledge, skills and confidence, and their communication needs; and* • *Helps staff deal with sensitive discussions such as consent, mental capacity, and end of life care*. **Year 2 - 2018/19** For Year 2, the provider will identify and agree a revised Cohort with the commissioner. This cohort will be drawn from the Year 1 Cohort and will thus be a sub-group of those patients who need further support in patient activation. Please see **Annex A** for guidance on Year 2 Cohort selection. In year two (2018/19), as in Year 1 above, organisations will either need to repeat the process of collecting individual Patient Activation scores using the Patient Activation Measure, or using the questions from the GP patient survey to ascertain levels of confidence and feelings of support, plus there are two further

Indicator 11	
	components: **1: Reporting on the number of care and support planning conversations** that take place (with the expectation that at least one conversation takes place for each patient but the number of conversations will vary depending on individual's needs and levels of knowledge, skills and confidence). **2: Conducting a follow up review of patient's knowledge, skills and confidence** for the identified patient cohort
Numerator & Denominator	**Year One:** 1. Develop and agree with commissioners a plan to ensure care & support planning is recorded by providers and how patients will be identified Local commissioners will need to be assured that the plan is appropriate and in place in a qualitative way. Plans are **NOT** to be submitted via SDCS. 2. The provider to identify a number of patients as having one or more LTCs compared to the total number of patients served. **AND** For all of these patients identified as having one or more LTCs to have a patient activation score recorded. Therefore Year 1 Part 2 indicator: $$Indicator = \left[\frac{\begin{array}{c} Number\ of\ patients\ identified \\ as\ having\ one\ or\ more\ LTCs\ who \\ have\ had\ an\ assessment\ made\ of \\ their\ activation\ level\ and\ score\ record \end{array} \quad (numerator)}{\begin{array}{c} Number\ of\ patients\ identified \\ as\ having\ one\ or\ more\ LTC \end{array} \quad (denominator)} \right] \times 100\%$$ **AND** To confirm the final cohort as the number of patients with one more LTCs and who have a low activation level (as described above).

Indicator 11	
	Therefore Year 1 Cohort : $$Year\ 1\ Cohort = \left[\begin{array}{c} Number\ of\ patients\ identified\ as\ having \\ one\ or\ more\ LTCs\ assessed\ AND\ as \\ having\ a\ low\ activation\ Level \end{array}\right]$$ This data should be submitted vis NHS Digital SCDS. 3. The provider to identify the number of staff who have undertaken training in personalised care and support planning. Therefore Year 1 Part 3 indicator: $$Indicator = \left[\frac{\begin{array}{c} Number\ of\ staff\ (identified\ by\ the\ provider \\ as\ caring\ forthe\ identified\ patient\ cohort\ ) \\ who\ have\ been \\ recorded\ as\ undertaking\ care\ and \\ support\ planning\ training \end{array}\ (numerator)}{\begin{array}{c} Total\ number\ of\ staff\ identified\ by \\ the\ provider\ as\ caring\ for\ the \\ identified\ patient\ cohort \end{array}\ (denominator)}\right] \times 100\%$$ This data should be submitted via NHS Digital SCDS. **Year Two:** 1. The number of patients from the Year 1 Cohort who have undertaken at least one personalised care and support planning conversation across both Year 1 and Year 2. Therefore Year 2 Part 1 indicator: $$Indicator = \left[\frac{\begin{array}{c} Number\ of\ patients\ in\ the\ Year\ 1 \\ identified\ patient\ cohort \\ who\ have\ had\ a \\ record\ of\ care\ and\ support\ planning \\ conversations \end{array}\ (numerator)}{\begin{array}{c} Number\ of\ patients\ in\ Year\ 1 \\ identified\ patient\ cohort \end{array}\ (denominator)}\right] \times 100\%$$ This data should be submitted via NHS Digital SCDS 2. Whether there has been an improvement in individual activation levels following personalised care and support planning.

Indicator 11	
	The provider will identify and agree a revised Year 2 Cohort with the commissioner. This cohort will be drawn from the Year 1 Cohort and will thus be a sub-group of those patients who need further support in patient activation. Please see **Annex A** for guidance on Year 2 Cohort selection. The Year 2 Part 2 denominator will be the number of patients in the Year 2 Cohort whose Patient Activation was measured, and the numerator will be the number of patients in the Year 2 Cohort whose Patient Activation level improved. Therefore Year 2 Part 2 indicator: $$Indicator = \left[\frac{The\ number\ of\ patients\ in\ the\ Year\ 2\ Cohort\ whose\ Patient\ Activation\ level\ improved\ (numerator)}{The\ number\ of\ patients\ in\ the\ Year\ 2\ Cohort\ (denominator)}\right] \times 100\%$$ This data should be submitted via NHS Digital SCDS
Data source	**Provider data collection** **Year One:** 1. Community based providers would need to agree a plan with their commissioner, outlining their approach to delivering personalised care and support planning to an identified cohort of patients, and how they will record this activity in a format that can be aggregated at organisation level. 2. Providers would need to identify which patient populations would benefit from personalised care and support planning and should be prioritised; using the list of long term conditions outlined in the GP Patient Survey and the Patient Activation Measure or GP patient survey criteria to assess their level of confidence and perceived support. 3. Providers would need to identify relevant staff (as defined above) and record that they have undertaken training in personalised care and support planning (as defined above). To be submitted via NHS Digital SDCS following locally agreed sign off processes by the commissioner. **Year Two:** 1. Identify the number of care planning conversations taking place for each of the identified cohort from the previously identified local system.

Indicator 11	
	2. Follow-up use of a survey instrument (the Patient Activation Measure or questions from the GP patient survey) to assess whether the level of patients' skills, knowledge and confidence to self-manage has improved.
Frequency of data collection	Annual in Q4, noting in-year milestones for year 1
Organisation responsible for data collection	Community Providers
Frequency of reporting to commissioner	Annual, noting in-year milestones for year 1
Baseline period/date	The requirements described are new. Baselines to inform Year 2 will be collected during Year 1.
Final indicator period/date (on which payment is based)	31 March 2018 (Year 1) and 31 March 2019 (Year 2)
Final indicator value (payment threshold)	**Year One:** 1. 25% of Year One CQUIN value a. No plan produced = 0% of proportion of CQUIN value. b. Plan produced but recording system not in place = 50% of proportion of CQUIN value. c. Plan produced and recording system put in place = 100% of proportion of CQUIN value. 2. 45% of Year One CQUIN value. Comprised of: **2.a) Identifying long term conditions (15% of Year One CQUIN value)** a. Relevant patients not identified or numbers submitted = 0% of proportion of CQUIN value. b. Relevant patients identified and numbers submitted to commissioner = 100% of proportion of CQUIN value. **2.b) Undertaking patient activation assessment (30% of Year One CQUIN value)** c. < 25% of patients in Year 1 cohort have a patient activation assessment = 0% of proportion of CQUIN value. d. 25 to 50% of patients in Year 1 cohort have a patient activation assessment = 50% of proportion of CQUIN value.

Indicator 11	
	e. 50% > of patients in Year 1 cohort have a patient activation assessment = 100% of proportion of CQUIN value. 3. 30% of Year One CQUIN value a. No staff identified for training = 0% of proportion of CQUIN value. b. Cohort of staff identified and list submitted to commissioner = 10% of proportion of CQUIN value. c. 33% to 66% of identified staff trained by end of year (including submitted staff list in 'b') = 40% of proportion of CQUIN value. d. 66 to 85% of identified staff trained by end of year (including submitted staff list in 'b') = 70% of proportion of CQUIN value. e. 85% > of identified staff trained by end of year (including submitted staff list in 'b') = 100% of proportion of CQUIN value. **Year Two:** 1. 50% of Year Two CQUIN value a. < 50% of patients in Year 1 Cohort have evidence of care and support planning conversations as recorded by provider = 0% of proportion of CQUIN value. b. 50 to 75% of patients in Year 1 Cohort have evidence of care and support planning conversations as recorded by provider= 50% of CQUIN value. c. 75% > of patients in Year 1 Cohort have evidence of care and support planning conversations as recorded by provider = 100% of CQUIN value. 2. 50% of Year Two CQUIN value a. < 25% of patients in Year 2 Cohort (subgroup of Year 1 cohort) demonstrate an improvement in their patient activation assessment = 0% of proportion of CQUIN value. b. 25 to 50% of patients in Year 2 Cohort (subgroup of Year 1 cohort) demonstrate an improvement in their patient activation assessment = 50% proportion of CQUIN value. c. 50% > of patients in Year 2 Cohort (subgroup of Year 1 cohort) demonstrate an improvement in their patient activation assessment = 100% of proportion of CQUIN value.
Final indicator	30th April 2018/19

Indicator 11	
reporting date	
Are there rules for any agreed in-year milestones that result in payment?	In-year milestones for Year 1 will be as follows: **By end of Q2:** A plan to ensure care & support planning is developed and recorded by providers will be a yes/no requirement. Likewise local commissioners will need to confirm whether the plan has been received and accepted by the end of the year (yes/no). **By end of Q3:** The provider to identify the number of patients as having multiple LTCs AND a low level of activation, who will be prioritised for personalised care and support planning (establishment of Year 1 cohort) compared to the total number of patients served. **By end of Q4:** 1. The provider to confirm what proportion of relevant staff have undertaken training in personalised care and support planning. 2. The provider to confirm the number of patients identified for the Year 1 cohort who have one or more LTCs and have been assessed as having a low activation level (as described above). There are no in-year milestones for Year 2
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Partial achievement of indicators is covered in the differing percentages of achievement within the ‘final indicator value’ section above.

Milestones for indicator 11

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Year 1 2017/18	Aplan to ensure care & support planning is developed and recorded by providers will be a yes/no requirement. Likewise local commissioners will need to confirm whether the plan has been received and accepted (yes/no).	end of Q2	25%
Year 1 2017/18	Provider to identify the number of patients as having multiple LTCs AND a low level of activation, who will be prioritised for personalised care and support planning (establishment of Year 1 cohort) compared to the total number of patients served.	end of Q3	15%
Year 1 2017/18	Provider to confirm the number of relevant staff caring for Year 1 cohort and what proportion of these staff have undertaken training in personalised care and support planning.	end of Q4	30%
Year 1 2017/18	Provider to confirm the number of patients identified for the cohort who have one or more LTCs and have been assessed as having a low activation level (as described above).	end of Q4	30%

Rules for partial achievement for indicator 11

The payment details are described in the final indicator value (payment threshold) in the table above.

Annex A – Cohort Selection

There are two steps to identifying the final cohort of patients who will benefit from this scheme. An initial cohort is identified in Year 1, and then this is revised in Year 2. Which patients are ultimately within each cohort is to be negotiated and agreed by the commissioner and the provider.

The cohort for Year 1 is those patients with a low patient activation level. Whilst Patient Activation Level of 1 or 2 using the PAM, or a score of 0 using the questions

from the GP Patient Survey, should be prioritised for Personalised Care and Support Planning; the final decision on which patients should be included and excluded in the Year 1 Cohort should be made by Trusts and Commissioners in partnership.

The revised cohort for Year 2 should be drawn from the Year 1 Cohort. The patients in the Year 2 Cohort should ideally be those still under the care of the provider trust, rather those who have been discharged. This is to make re-assessing patient activation level easier, as patients will not have to be contacted and followed up after discharge.

Annex B – Patient Activation Measure Licences

There are no Patient Activation Measure licences held by NHS England to support measurement of Patient Activation as part of this CQUIN scheme. All PAM Licences procured nationally have been allocated to individual organisations. Whilst, if you do not have licences, it is possible for your trust or commissioner to procure additional licences for the PAM through Insignia Health, you are strongly advised to use questions 32 and 33 drawn from the GP Patient survey instead, as described in Indicator 11 under the ***Description of Indicator*** section on page 138-139.

12. Ambulance conveyance

Indicator 12	
Indicator name	A reduction in the proportion of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E Department. *Please note that due to the refresh of the Ambulance Quality Indicators during 2017, the indicator description, numerator and denominator have been updated accordingly. In Year 1, Ambulance Services will need to use the Year 2 numerator and denominator from the point of reporting against the refreshed AQIs.
Indicator weighting (% of CQUIN scheme available)	0.25%
Rationale for inclusion	The first stage report of Professor Sir Bruce Keogh's review of Urgent and Emergency Care (the "Review") described the untapped potential of English ambulance services, and the need to expedite the ongoing transformation of these services from a transport to a treatment role. As a result of these changes the ambulance service will become a community-based provider of mobile urgent and emergency healthcare, fully integrated within Urgent and Emergency Care Networks. This indicator incentivises managing care closer to home and a reduction in the rate of ambulance 999 calls that result in conveyance to A&E. At present, the majority of patients who dial 999 are attended by an ambulance clinician. Many of these are then transported to an A&E Department despite the fact that this may not be the best place to meet the patient's needs. It is proposed that a number of pathways are used as an alternative to the current default conveyance to Accident and Emergency (A&E). Commissioners should utilise Urgent Treatment Centres, staffed by a multi-disciplinary team, and ensure that these accept patients conveyed to them by ambulance under agreed protocols and care pathways: other alternative care pathways are described later in the document. Other pathways are an alternative to conveyance of any kind, for selected patients contacting the 999 service: these include "hear and treat" and "see and treat". A reduction in the level of this indicator suggests patients with urgent care needs are treated in the right place, with

Indicator 12	
	the right facilities and expertise, at the right time. The introduction of enhanced training and protocols for ambulance clinicians, better data sharing across the system, improved clinical support and advice to the ambulance service from a range of healthcare professionals in clinical hubs and/or the provision of alternative care pathways would all be expected to have a positive impact on this indicator. It is acknowledged that some of these 'enablers' are outside the direct control of ambulance providers. Measurement of the conveyance rate, along with consideration of baselines for hear and treat and see and treat will enable the development of a trajectory to reduce conveyance to type 1 and type 2 A&E Departments.
Description of indicator	Proportion of 999 incidents which result in transfer of the patient to a Type 1 or Type 2 A&E Department.
Numerator	**Year 1** Number of emergency calls (through 999 or 111) that receive a face-to-face response from the ambulance service and result in transport to a Type 1 or Type 2 A&E Department. **Year 2** Number of Ambulance Service incidents with any patients transported to an Emergency Department (type 1 / type 2 A&E Department). Item A53 from Data source below.
Denominator	**Year 1** Number of emergency calls (through 999 or 111) that receive a telephone or face-to-face response from the ambulance service*. *A telephone response includes transfer to, or call-back from, a clinician in the emergency control centre or a clinical hub as well as the full use of the NHS Pathways system by a suitably trained call handler. **Year 2** Number of Ambulance Service incidents. Comprises not only calls that receive a face-to-face

Indicator 12	
	response from the ambulance service at the scene of the incident, but also calls that are successfully resolved with telephone advice with any appropriate action agreed with the patient. Item A7 from Data source below.
Data source	Latest Systems Indicators specification document (20170926 at time of writing) and Time Series spreadsheet at www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators
Frequency of data collection	Quarterly
Organisation responsible for data collection	Ambulance Services
Frequency of reporting to commissioner	Quarterly
Baseline period/date	**Year 1** - 2016-17 **Year 2** - Baselines created based on available AQI data, accounting for seasonal variation and will be communicated via lead commissioners.
Final indicator period/date (on which payment is based)	Year 1 – 2017-18 Year 2 – 2018-19
Final indicator value (payment threshold)	**Year 1:** *Implementation of enablers (80%) (individual weighting and definitions given below)* 1. PDS Matching 20% 2. SCR Look-up 15% 3. DoS search 15% 4. System of support and governance for clinicians 15% 5. Workforce Plan focussed on urgent care 15% *Outcome Thresholds (20%) – individual weighting below* 1. Maintenance of current baseline based on existing rates of H&T and S&T 10% 2. Reductions in conveyance to Type 1 & Type 2 A&E agreed locally with commissioners 10% **Year 2:** *Implementation of enablers (20%)* Development and implementation of a plan to reduce the proportion of 999 incidents resulting in transport to Type 1

Indicator 12	
	and Type 2 A&E Departments. This should be based on analysis within year one of relevant local indicators ie H&T & S&T and in accordance with the results of the VAN[59] study and the refreshed Ambulance Quality Indicators. Due to the recent refresh of AQI reporting Commissioners are unable to set baselines for H&T and S&T. Consequently, the national analytical team have agreed to develop these local baselines along with a baseline for conveyance to type 1 and type 2 A&E Departments. These will be available to commissioners Mid-March 2018. *Outcome Thresholds (80%)* Reduction in the proportion of 999 incidents resulting in transport to Type 1 and Type 2 A&E Departments, as agreed locally. Partial payment of the CQUIN monies will be awarded dependent on level of achievement of targets established. These have been revised for 2018/19.
Final indicator reporting date	2 year CQUIN 2017/18 and 2018/19 respectively May 2018 and May 2019.
Are there rules for any agreed in-year milestones that result in payment?	Enablers defined as below: 1. Personal Demographics Service (PDS) matching 2. Summary Care Record (SCR) lookup 3. Directory Of Services access 4. Workforce support 5. Develop a career pathway Further detail is provided in the supplementary guidance for indicator 12.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	**Year 1**: % allocation for each milestone **Year 2:** We will award partial payment of the CQUIN monies dependent on achievement of targets established as a result of the refreshed Ambulance Quality Indicators.
EXIT Route	To be determined locally

[59] A larger piece of work on Ambulance conveyance is currently under way with the University of Sheffield, School of Health and Related Research (ScHaRR). The Variation in Ambulance Non-conveyance (VAN) Study will highlight issues affecting non-conveyance rates. Once published, Ambulance services could use the evidence to help them identify new strategies for managing non-conveyance. Once Hear and Treat has been established within Trusts, this will act as an enabler for further services to be reviewed and developed for the See and Treat part of the programme.

Milestones for indicator 12

Date / period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 4 (Year 1)	Enablers (80%): 1. PDS Matching 2. SCR Look-up 3. DoS search 4. System of support and governance for clinicians 5. Workforce Plan focussed on urgent care	End of Q4	 20% 15% 15% 15% 15%
Quarter 4 (Year 1)	Outcome Thresholds (20%): 1. Maintenance of current baseline based on existing rates of H&T and S&T 2. Reductions in conveyance to Type 1 & Type 2 A&E Departments agreed locally with commissioners	End of Q4	 10% 10%
Quarter 4 (Year 2)	Enablers (20%) Development and implementation of a plan to reduce the proportion of 999 incidents resulting in transport to Type 1 and Type 2 A&E Departments.	End of Q4	20%
Quarter 4 (Year 2)	Outcome Thresholds (80%) Locally agreed reduction in proportion of 999 incidents resulting in transport to Type 1 and Type 2 A&E Departments.	End of Q4	80%

Rules for Partial Achievement of Indicator 12

In Year 2 there will be a staged payment dependent on level of achievement against targets established as a result of the refreshed Ambulance Quality Indicators. This will reward partial achievement of the CQUIN target with partial payment.

Quarter 4: 2018/19

Final indicator value for partial achievement of the outcome threshold	% of CQUIN scheme available for meeting the outcome threshold
Achieved less than 33.9% of locally determined target	No payment
Achieved 34% - 50.9% of locally determined target	50%
Achieved 51% - 89.9% of locally determined target	75%
Achieved 90 - 100%+ of locally determined target	100%

The implementation of the year 2 enablers, (a total 20%), will be paid upon development and implementation of a plan, which has been agreed with Commissioners, to reduce the proportion of 999 incidents resulting in transport to Type 1 and Type 2 A&E Departments. If a plan is not developed and implemented, the 20% CQUIN will not be achieved.

Worked Examples

1. **Ambulance Service A** had a target to develop and implement a plan to reduce the proportion of 999 incidents resulting in transport to Type 1 and Type 2 A&E Departments (enabler) and reduce its conveyance rate by 10% (outcome).

- A plan was developed and implemented which results in all of the available 20% enablers CQUIN funding being earned.
- The conveyance rate was reduced by 3.5%, which was 35% of the locally determined target. As a result, they would receive 50% of the funds available for meeting the outcome threshold (80%), which would be 40%.

In total, Ambulance Service A has been awarded 60% out of a total 100% of their funding (20% + 40%).

2. **Ambulance Service B** had a target to develop and implement a plan to reduce the proportion of 999 incidents resulting in transport to Type 1 and Type 2 A&E Departments (enabler) and reduce its conveyance rate by 10% (outcome).

- A plan was developed but not implemented which results in none of the available 20% enablers CQUIN funding being earned.
- The conveyance rate was reduced by 7%, which was 70% of the locally determined target. As a result, they would receive 75% of the funds available for meeting the outcome threshold (80%), which would be 60%.

In total, Ambulance Service B has been awarded 60% out of a total 100% of their funding (0% + 60%).

3. **Ambulance Service C** had a target to develop and implement a plan to reduce the proportion of 999 incidents resulting in transport to Type 1 and Type 2 A&E Departments (enabler) and reduce its conveyance rate by 10% (outcome).

- A plan was developed and implemented which results in all of the available 20% enablers CQUIN funding being earned.
- The conveyance rate was reduced by 15% which exceeded their locally determined target/ As a result, they would receive 100% of the funds available for meeting the outcome threshold (80%).

In total, Ambulance Service C has been awarded 100% of their funding (20% + 80%).

Supporting Guidance for ambulance conveyance CQUIN indicator 12

The enablers are defined below:

1. Personal Demographics Service (PDS) matching

Matching patient's details at point of call is a key enabler to accessing both the full directory of services and also the summary care record. PDS matching also enables review of patients across the urgent and emergency care system.

- Establish the technical ability to PDS match patients at point of emergency call.
- Train call handlers in undertaking PDS matching.

Evidence required:

- Technical plan.
- Successful implementation of plan.
- Locally agreed percentage increase in number of successful matches as a proportion of green calls received.

2. Summary Care Record (SCR) lookup

The summary care record contains key patient information to facilitate decision making relating to conveyance. As such for calls subject to clinical assessment in control rooms the clinician should access the SCR.

- SCR available within the call centre.
- Train clinical call centre staff in use of SCR.

Evidence required:

- Percentage of clinical staff trained in use of SCR.
- Locally agreed percentage increase in number of SCR accessed as a proportion of calls subject to clinical triage.

3. Directory Of Services access

To effectively refer patients to alternatives to emergency departments requires access and utilisation of a directory of services. This can be achieved directly by clinicians using MiDoS, pathways etc. or via accessing the clinical hubs for service provision.

- Establish access method for the DoS.
- Train staff in use.
- Consider with commissioners any deficit in services.

Evidence required:

- Percentage of clinical staff trained in the use of DoS.
- Locally agreed percentage increase in the number of DoS lookups as a proportion of patient interactions.

4. Workforce support

Key to safe and effective clinical decision making is an ongoing programme of support and learning through feedback for the workforce. Providers should develop a system of support and governance focussed on providing a supportive and challenging environment to learn in a peer reviewed system. This should be in-line with best practice guidance from professional bodies.

- Develop and agree workforce support programme.

Evidence required:

- Agreed programme.
- Plan of delivery across clinical workforce.

5. Develop a career pathway

In addition to the support identified at section 4, in order to maximise safe and effective non-conveyance rates providers need a range of skills and competencies in a clinical workforce which may include specialist and advance practitioners with leadership from Consultant level practitioners. Such practice development will be included in unscheduled, urgent and also critical care as well as in telephone/remote practice environments, including in supporting clinically intelligent dispatching. Providers should develop a comprehensive workforce plan that ensures its clinicians have the necessary capabilities and competences required to safely assess, diagnose, treat and refer patients within the community, thus meets the need of achieving non-conveyance and matches national career frameworks.

Evidence required:

- Locally agreed plan with commissioners to include number at each skill level and education requirements.
- Locally agreed achievement against workforce plan that meets population needs.

Note - There will be some data development requirements to establish these enablers. These requirements will be analysed and established during the establishment of this CQUIN scheme.

13. NHS 111 referrals

Indicator 13	
Indicator name	Increasing the proportion of NHS 111 referrals to services other than to the ambulance service or A&E departments.
Indicator weighting (% of CQUIN scheme available)	0.25%
Rationale for inclusion	The strategic direction as set out in the Five Year Forward View, and the Urgent and Emergency Care Review, is that UEC services are configured with the aim of managing patients with urgent care needs closer to home rather than in a hospital (A&E or inpatient) setting. This CQUIN scheme will help realise that strategic aim for patients triaged through NHS 111, specifically that referrals to 999 and A&E are only made when most appropriate. Two of the three components directly link payment to reductions in such referrals. The third encourages improved data capture of dispositions for service improvement, quality of the Directory of Services (DOS) as well as to inform a basis for payment of the CQUIN. This CQUIN is designed to incentivise providers to ensure only those patients which need to go to either the ambulance service or A&E are referred. Where an alternate service is available it should be used. Where an IUC model is being implemented commissioners should ensure that the CQUIN incentive is only used where there have not been renewed contract arrangements where potential additional costs have already been accounted for.
Description of Indicator	There are three parts to this scheme: 1. Measuring the percentage of NHS 111 calls triaged that have ambulance as a final disposition; 2. Measuring the percentage of NHS 111 calls triaged that have A&E as a final disposition; and 3. Measuring the number of times where there is no alternate service to A&E or ambulance.
Numerators	1. The number of NHS 111 calls triaged with an emergency ambulance as a final disposition (NHS 111 MDS item 5.23 when transitioned to IUC MDS data items are 5.6.1.1 + 5.6.2.1 + 5.6.3.1); 2. The number of NHS 111 call triaged with A&E as a final

Indicator 13	
	disposition (NHS 111 MDS item 5.24, when transitioned to IUC MDS data items are 5.6.1.2 + 5.6.2.2 + 5.6.3.2); and 3. The number of NHS 111 calls triaged that have either an A&E or emergency ambulance as a final disposition where there was no other service in the DoS results list other than an A&E or ambulance service.
Denominators	1. The number of NHS 111 calls triaged (NHS 111 MDS item 5.11, when transitioned to IUC MDS data item is 5.4.1.1) 2. The number of NHS 111 calls triaged (NHS 111 MDS item 5.11, when transitioned to IUC MDS data item is 5.4.1.1). 3. The number of NHS 111 calls triaged that have A&E or ambulance as a final disposition (NHS 111 MDS data items 5.23+5.24 when transitioned to IUC MDS data items are 5.6.1.1+5.6.2.1+5.6.3.1 plus 5.6.1.2+5.6.2.2+5.6.3.2)
Data source	Indicators 1 and 2: 999 and A&E referrals • NHS 111 Minimum Data Set, NHS England • https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/During 2018/19 it is expected that the Integrated Urgent Care (IUC) Minimum Dataset will become live and be the data source for 111 activity and referrals. Indicator 3: Directory of Services returns • DoS Returns • Provider systems
Frequency of data collection	Monthly
Organisation responsible for data collection	NHS England
Frequency of reporting to commissioner	To be agreed locally
Baseline period/date	2016/17
Baseline value	Baseline for performance for 999 referrals and A&E dispositions will be derived for full year average from NHS 111 MDS https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/nhs-111-minimum-data-set-2016-17/ data items 5.23, 5.24 and 5.11. Baseline will be calculated on a NHS 111 contract area basis.

Indicator 13	
Final indicator period/date (on which payment is based)	2 year CQUIN 2017/18 and 2018/19
Final indicator value (payment threshold)	1. 999 referrals A 10% reduction in the proportion of NHS 111 calls triaged that end with a 999 referral from baseline between 2016/17 and 2018/19. 2. A&E disposition A 10% reduction in the proportion of NHS 111 calls triaged that end in an A&E disposition from baseline between 2016/17 and 2018/19. 3. Directory of Services Results List The recording and collection of data relating to services in the DoS results list other than an A&E or ambulance service (2017/18 only).
Final indicator reporting date	2 year CQUIN 2017/18 and 2018/19 respectively May 2018 and May 2019.
Are there rules for any agreed in-year milestones that result in payment?	To be agreed locally.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Recommended rules for partial achievement are described in the table below. There are differences between year one and year two because the data collection requirement is for year one only, and then becomes a gateway for payment in year two. Payment thresholds are recommended and should account for developments such as the introduction of a clinical hub as appropriate. Patient safety in urgent and emergency care is paramount and should partial payments need to be adjusted locally on the grounds of patient safety then this can be done accordingly, in agreement between commissioners and providers. The CQUIN is designed to improve accurate patient referral; patients must only be referred where the service is clinically appropriate for the patient's condition.
EXIT Route	To be agreed locally

Milestones for indicator 13

Payment made based on year-end performance.

Rules for partial achievement for indicator 13

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value	
	Year 1 (2017/18)	Year 2 (2018/19)
10% reduction in 999 referral	45%	50%
10% reduction in A&E disposition	45%	50%
8% reduction in 999 referral	35%	40%
8% reduction in A&E disposition	35%	40%
5% reduction in 999 referral	20%	25%
5% reduction in A&E disposition	20%	25%
Recording of DoS Results List	10% (2017/18 only)	Gateway milestone

Supporting Guidance and References

- Any change to the use of 111 services locally, for example its use as a gateway to access GP out of hours, may change the proportion of ambulance and ED dispositions. Any such changes should be taken into account when setting local levels of improvement.

- It is essential that patients continue to be referred to whichever urgent and emergency care service is identified as being most clinically appropriate to their needs. Local audits of 111 call outcomes and clinical review of adverse events should be considered to ensure that patients are being referred appropriately.

- Integrated Urgent Care (IUC) is being rolled out over the period of this CQUIN and is intended to replace and enhance the current NHS 111 service. Further details on the planned delivery of IUC are available from the following link: https://www.england.nhs.uk/ourwork/pe/nhs-111/resources/